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Editorial
Άρθρο σύνταξης

Combination of psychodynamic psychotherapy and pharmacotherapy for patients with Personality Disorders: Recent findings

Psychiatriki 2014, 25:167–170

Personality Disorders are the most controversial diagnostic entities in modern psychiatry. However, there is a common ground in the field of treatment: the psychotherapy of patients with Personality Disorders is the treatment of choice. Research data confirm this assumption, especially for individual psychodynamic and cognitive - behavior psychotherapy.[1]

From the 80s onwards, new psychotherapeutic interventions were developed to achieve profound changes to the character pathology of the most serious cases with Personality Disorders, utilizing the existing psychiatric settings (inpatient wards or day hospitals). The latter were taken as the necessary framework (or containing, in psychoanalytic terminology) parameter for dealing with the enactments and suicidal behaviors of these patients.[2] Psychotherapy always is multimodal, with the concomitant administration of individual and group sessions and expressive psychotherapies as well. The prevailing model is psychodynamic.

Nowadays we have many studies showing that these forms, combining psychiatric and intensive psychotherapeutic approach, provides statistically significant positive results compared to treatment as usual on an outpatient basis or hospitalization without psychotherapeutic orientation.

The research groups headed by Chiesa[3,4] and Vermote[5] for inpatient treatment and Karterud[6,7] and Bateman & Fonagy[8,9] for partial hospitalization have given clear evidence of efficacy concerning the treatment of Personality Disorders.

Finally, in our research work, using a naturalistic methodology, the psychotherapy- based inpatient treatment of seriously ill patients with Personality Disorders (mean average 4.5 DSM-IV diagnoses) was evaluated.[10] 57% of the subjects received medication adjunct to psychotherapy. Our study showed that for the group of patients who received only psychotherapy within the inpatient framework there was effectiveness to a significant degree, in relation to their impulsivity, but not to suicidality. In the latter, a combination of medication and psychotherapy was superior. These results need confirmation as they are the first regarding the combined pharmacotherapy and psychotherapy treatment in cases of severe Personality Disorders. In any case, it shows the way for the convergence of psychodynamic practice along with psychiatric and psychopharmacological practice to treat seriously ill patients with Personality Disorders.

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Συνδυασμός ψυχοδυναμικής ψυχοθεραπείας και φαρμακοθεραπείας σε ασθενείς με Διαταραχές Προσωπικότητας: Νεότερα δεδομένα

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Οι Διαταραχές Προσωπικότητας αποτελούν το πιο αμφιλεγόμενο διαγνωστικό όρο της σύγχρονης ψυχιατρικής. Όμως υφίσταται ένας κοινός τόπος στο πεδίο της θεραπευτικής αντιμετώπισης: η ψυχοθεραπεία των ασθενών με Διαταραχές Προσωπικότητας αποτελεί απαραίτητη θεραπευτική πρόταση. Ερευνητικά δεδομένα επιβεβαιώνουν την παραδοχή αυτή, ιδίως για την ψυχοδυναμική και τη γνωσιακή-συμπεριφορική ατομική ψυχοθεραπεία.[1]

Από τη δεκαετία του '80 και μετά αναπτύχθηκαν ψυχοθεραπευτικές παρεμβάσεις με στόχο να πετύχουν βαθιές αλλαγές στη χαρακτηριολογική παθολογία των πιο σοβαρών περιπτώσεων με Διαταραχές Προσωπικότητας, αξιοποιώντας τα υπάρχοντα ψυχιατρικά πλαίσια (ενδονοσοκομειακά τμήματα, νοσοκομεία ημέρας). Τα τελευταία θεωρήθηκαν ως ο αναγκαίος συγκρατητικός (ή εμπεριέχων, κατά την ψυχαναλυτική ορολογία) παράγων για την αντιμετώπιση των εκδραματίσεων και των αυτοκαταστροφικών συμπεριφορών των ασθενών αυτών.[2] Η ψυχοθεραπεία νοείται ως πολύμορφη (multimodal), με την παράλληλη χορήγηση ατομικών και ομαδικών συνεδριών καθώς και εκφραστικών ψυχοθεραπειών. Το επικρατέστερο μοντέλο είναι το ψυχοδυναμικό.

Σήμερα διαθέτουμε πολλές έρευνες που δείχνουν ότι οι μορφές αυτές συνδυασμού ψυχιατρικού πλαισίου και εντατικής ψυχοθεραπευτικής προσέγγισης παρέχει στατιστικά σημαντικά θετικά αποτελέσματα σε σύγκριση με τις κοινές θεραπευτικές παρεμβάσεις σε εξωνοσοκομειακή βάση ή με τις νοσηλείες χωρίς ψυχοθεραπευτικό προσανατολισμό.

Οι ερευνητικές ομάδες με επικεφαλείς τους Chiesa[3,4] και Vermote[5] για την ενδονοσοκομειακή θεραπεία και τους Karterud[6,7] και Bateman & Fonagy,[8,9] για τη μερική νοσηλεία, έχουν δώσει σαφείς ενδείξεις για την αποτελεσματικότητά τους στη θεραπεία των Διαταραχών Προσωπικότητας.

Τέλος, σε πρόσφατη ερευνητική μας εργασία,[10] νατουραλιστικής μεθοδολογίας, δώσαμε δεδομένα από την ενδονοσοκομειακή θεραπεία σοβαρά πασχόντων ασθενών με Διαταραχές Προσωπικότητας (που πληρούσαν τα κριτήρια για, κατά Μ.Ο., 4.5 διαγνώσεις σύμφωνα με το DSM-IV). Σε ποσοστό 57% οι ασθενείς ελάμβαναν φαρμακευτική αγωγή επιπροσθέτως της ψυχοθεραπευτικής αντιμετώπισης. Η μελέτη μας έδειξε ότι η χορήγηση μόνο ψυχοθεραπείας, πάντα εντός του ενδονοσοκομειακού πλαισίου, ήταν αποτελεσματική –σε στατιστικά σημαντικό επίπεδο– στην έκβαση της θεραπείας ως προς την παρορμητικότητα των ασθενών, όχι όμως ως προς την αυτοκτονικότητα τους. Στην τελευταία υπέρτερη ήταν η χορήγηση συνδυασμού φαρμακευτικής αγωγής και ψυχοθεραπείας. Τα αποτελέσματα αυτά χρειάζονται επιβεβαίωση καθώς είναι τα μόνα στη βιβλιογραφία σχετικά με τον συνδυασμό ψυχοθεραπευτικών προγραμμάτων και φαρμακοθεραπείας σε σοβαρές περιπτώσεις Διαταραχών Προσωπικότητας. Σε κάθε περίπτωση, δείχνουν τον δρόμο για τη σύγκλιση των ψυχοδυναμικών πρακτικών με την τρέχουσα ψυχιατρική και ψυχοφαρμακολογική πρακτική για τη θεραπεία σοβαρά πασχόντων ασθενών με Διαταραχές Προσωπικότητας.

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Research article
Ερευνητική εργασία

Constraint and loneliness in agoraphobia: An empirical investigation

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While progress in the aetiopathology and treatment of panic disorder is indisputable, research regarding agoraphobia lacks behind. One significant-yet untested- theory by Guidano and Liotti, suggests the existence of inner representations of fear of "constraint" and fear of "loneliness" as two major schemata, important in the pathogenesis and manifestation of agoraphobia. Activation of these schemata may occur in situations in which the patient: (a) feels as in an inescapable trap (constraint) or (b) alone, unprotected and helpless (loneliness). Upon activation, the "constraint" schema elicits such symptoms as asphyxiation, chest pain, difficult breathing, motor agitation and muscular tension, while the "loneliness" schema elicits such symptoms as sensation of tachycardia, weakness of limbs, trembling or fainting. Activation of these schemata by content-compatible stimuli is expected to trigger various, yet distinct, response patterns, both of which are indiscriminately described within the term "agoraphobia". In order to investigate this hypothesis and its possible clinical applications, several mental and physical probes were applied to 20 patients suffering primarily from agoraphobia, and their responses and performance were recorded. Subjects also completed the "10-item Agoraphobia Questionnaire" prepared by our team aiming at assessing cognitions related to Guidano and Liotti's notion of "loneliness" and "constraint". Breath holding (BH) and Hyperventilation (HV) were selected as physical probes. BH was selected as an easily administered hypercapnea - induced clinical procedure, because of its apparent resemblance to the concept of "constraint". Subjects were instructed to hold their breath for as long as they could and stop at will. Similarly, it was hypothesized that HV might represent a physical "loneliness" probe, since it can elicit such symptoms as dizziness, paraesthesias, stiff muscles, cold hands or feet and trembling, reminiscent of a "collapsing type" symptomatology. Patients' responses and performance were recorded by visual analogue scales and heart rate and respiratory rhythm were being registered continuously. Although the overall elicited symptoms were not differentiated in a meaningful way, a significant correlation was registered between duration of physical probes and scoring of the "10-item Agoraphobia Questionnaire". Duration of BH was inversely correlated ($r=-0.456$, $p<0.05$) with the score of the 5 "constraint-type" agoraphobic items

while duration of HV was inversely correlated (r=−0.479, p<0.03) with the score of the 5 "loneliness-type" agoraphobic items. Assuming that our questionnaire taped the "loneliness" and "constraint" schema threat, our hypothesis derived from Guidano & Liotti's assumptions was partially confirmed.

Key words: Agoraphobia, constraint, loneliness, breath holding, hyperventilation.

Introduction

The relationship between panic disorder and agoraphobia is far from clear.[1] Furthermore, although, DSM-IV ascribes a status to each of them separately, as well as in combination,[2] the diagnosis of agoraphobia as a clinical entity of its own, is on the waning.[3,4] This trend can be also traced in the psychotherapeutic practice where panic disorder takes preponderance over agoraphobia, the latter being implicitly or explicitly viewed as a psychopathological state secondary to panic,[5] an attitude in contrast to the one displayed by the early behaviorists.[6] To that respect, the theoretical model described by Guidano and Liotti[7] may be an advanced working hypothesis for the study of agoraphobia, as an entity of its own.

According to this hypothesis agoraphobic patients represent a course of attachment behavior characterized by a detachment blockage, with more or less conspicuous hampering of exploratory behavior. The detachment blockage is usually created with indirect patterns, as opposed to a direct prohibition of exploration. The more common of these patterns are: (a) Continuous warning from hyperprotective patterns on the dangers of the outside world and therefore on the difficulties in dealing with it. (b) Insistence on the child's presumed physical and/or emotional weakness, which makes him or her particularly exposed to the world's dangers. (c) Modeling on the agoraphobic parent who, fearing loneliness, keeps the child with him or her. (d) Threats of desertion or family scenes that make the child insecure outside of the home. The anxious attachment that emerges provides the child with a conflicting self image since the continuous contact and attention from the parents to the child provide him or her with a self image as a lovable and valuable person whereas the continuous limitation of exploration furnishes him or her with a weak and/or fragile self- image within a threatening and hostile world. The individual has difficulties reaching the equilibrium between the efforts needed to obtain protection and to maintain the sense of freedom and independence. This attitude towards reality becomes precarious as soon as the individual finds himself or herself confronting those specific situations that represent the dilemma, that is : possible loss of protection (e.g. a situation of loneliness threatened by the possible breaking off of a sentimental relationship) or possible loss of the sense of freedom and independence (e.g. finding oneself involved in a stable affective relationship with a "controlling" partner or with one who escapes the possibilities of control). Agoraphobic patients' avoidance behavior discloses the existence of two large categories of stimulus situations that are avoided: loneliness and constrain. The majority of agoraphobic patients avoid staying alone for long periods in their own homes, on the street, or in public places where there are no familiar or trusted people. Certain situations are also avoided even when a trusted companion is nearby. This is when a quick escape is difficult or impossible: crowded places (theaters, movie houses), streets with many traffic lights and heavy traffic, superhighways, planes or trains, elevators. The two categories of feared stimuli exist simultaneously in the majority of agoraphobic patients Guidano and Liotti speculate that activation of the two large categories of stimulus- situations (schemata) in agoraphobia "constraint" and "loneliness" may trigger distinct somatic as well as psychological responses. Upon activation, the "constraint" schema elicits such symptoms as asphyxiation, chest pain, difficult breathing, motor agitation and muscular tension, while the "loneliness" schema elicits such symptoms as sensation of tachycardia, weakness of limbs, trembling or fainting (Guidano & Liotti, p. 206). If this hypothesis is confirmed, it might further delineate the psychopathological picture of agoraphobia, and contribute to the formulation of a more comprehensive therapeutic approach.

The aim of this study is to evaluate the performance and the response of agoraphobic patients to the administration of distinct (specific) anxiety-eliciting probes and their relationship –if any– to Guidano and Liotti's "loneliness" or "constraint" hypothesis.

Material and method

Subjects

Twenty consecutive consenting drug free agoraphobic patients referred for Cognitive Therapy at the Outpatient Clinic of the First Department of Psychiatry at the Athens University Medical School, Eginition Hospital, participated the study. Diagnosis was re-established with a thorough clinical evaluation, whether the patients met the DSM-IV criteria for agoraphobia with or without panic attacks agoraphobia.[2] Seven (7) males and thirteen (13) females, their age ranged from 19 to 44 y/o (mean: 30.3 SD+/– 6.5 y/o). All patients fulfilled the criteria for agoraphobia with history of previous or present panic attack, and none of the participants suffered from only panic disorder, without agoraphobia. Patients that did not fulfill the DSM-IV criteria or had another comorbid mental disorder or somatic illness were not included in the study.

All patients completed a "10-item Constrain and Loneliness Questionnaire" prepared by our team aiming at assessing cognitions related to Guidano and Liotti's notion of "loneliness" and "constraint". The items were selected from the DSM-IV and ICD-10[8] diagnostic guidelines and clinical descriptions, Marks and Mathews' 5-item Agoraphobia factor from the Fear Questionnaire[9] and from Chambless et al "Mobility Inventory for Agoraphobia".[10] The items consist of five (5) dealing with situations suggestive of a "constraint-type" of threat ("trapped" and "inescapable") and five (5) with situations suggestive of a "loneliness-type" of threat (alone and unprotected). Patients were asked to rate the frequency of the avoidance they displayed on a five- point scale (see appendix).

Procedure

During the experimentation day subjects were individually given imagery stimuli followed by physical stimuli.

Imagery probes

Two sets of cognitive stimuli in the form of stories lasting two minutes were prepared and presented to the patients mainly aiming at activating the hypothesized corresponding cognitive domains. Both involved imaging places or situations in which either escape is difficult or help might not be available if needed. The structure of the text given to subjects was identical for all, except that the particular situation representing the best example of the "loneliness" threat or the "constraint" threat was obtained from their completed the "10-item Constrain and Loneliness Questionnaire", and incorporated in the plot of the text. Patients indicated by raising their thumb that they managed to imagine successfully the particular situation (Texts are available upon request).

Physical probes

Since no formal physical probes exist aiming at exclusively activating the "constraint" and "loneliness" cognitive domain, we chose to apply physical stimuli relevant to the notion of "constraint" and "loneliness" in a least- stressful format and evaluate subjects' performance and/or possibly elicited symptoms.

Many patients being in "trapped" places report experiencing difficulties in breathing, tightness in the chest, palpitations, or a feeling of suffocation, symptoms that can be elicited by hypercapnea induced by $C0_2$ administration.[11] Breath holding (BH) was selected as an easily administered hypercapnea-induced clinical procedure, because of its apparent resemblance to the concept of "constraint".

The patient was asked to take a deep inhalation of room air and to hold his breath for as long as possible. The patient pushed his nostrils closed with his fingers and closed his mouth completely immediately after the end of the deep inhalation, and kept them closed during the BH. He removed his fingers from his nose as soon as he terminated the BH test. The examiner was behind him, measuring the BH duration with an electronic chronometer

Similarly, it was hypothesized that "hyperventilation" (H/V) might represent a physical "loneliness" probe, since it can elicit such symptoms as dizziness, paraesthesias, stiff muscles, cold hands or feet and trembling,[12] reminiscent of a "collapsing type" symptomatology. Subjects were asked to hyperventilate, i.e. deep and fast breathing, for about 60 breaths/min, for as long as they could and stop at will. The examiner was behind him, measuring duration time with an electronic chronometer

Measurements

A Visual Analogue Scale VAS (0–100) for the 13 items of DSM-IV Panic Attack was completed before

and after each stimulus. Each of the VAS consisted of a 10 cm line ranging from 0 "I don't feel it at all" to 100 "I feel it excessively", (table 1).

Statistical analysis

Descriptive statistics were used to explore the sample's demographic and clinical characteristics. The Sperman's (rho) coefficient was used to calculate bivariate correlation between the dependent variables (Loneliness VAS story, Constriction VAS story, BH VAS, HV VAS, BH time, HV time) and the independent variables (age, gender).

Results

Descriptive statistics from the available variables to enter in the analysis are presented in table 2. Regarding the "10-item Constrain and Loneliness Questionnaire" the 20 agoraphobic patients rated an avoidance level of 427.5±196.3 For the 5 items representing the loneliness scale the mean avoidance score was 243.7±131.5 while for the 5 items representing the constrain avoidance patients scored 183.7±100.4 ($p<0.000$).

The symptoms elicited by the two mental probes as measured in the VAS of the 13-items of DSM-IV for panic attack were more intense for the constrain situation (117.9±153.8) compared to that elicited by the loneliness situation (62.1±105) ($p=0.001$)

The correlation matrix of all variables in the study are presented in table 2. Significant correlations between the score of avoidance in both constrain and loneliness situation were found for the physical probes but not for the mental ones.

The total score of the five items of the agoraphobic scale representing the "constraint" construct was inversely correlated with the breath holding (BH) duration ($r=-0.456$, $p<0.05$). On the other hand, the total score of the five items of the same scale representing the "loneliness" construct was inversely correlated

Table 1. Descriptive statistics from the variables entered in the analysis. (Data from 20 agoraphobic patients).

	Mean	*Standard deviation*	*Min-Max*
Age (years)	30.3	6.5	19–44
Loneliness scale	183.7	100.4	25–425
Constriction scale	243.7	131.5	25–425
BH time (sec)	41	20	7–67
HV time (sec)	68.4	39.7	19–184
Loneliness VAS story	62.1	105	0–380
Constriction VAS story	117.9	153.8	0–450
BH VAS	95.2	91.5	0–300
HV VAS	252.7	232.4	20–880

Loneliness scale	Sum of scores for the five items of the "10-item Constrain and Loneliness Questionnaire" Scale suggestive of a loneliness-type of threat that patients avoid
Constriction scale	Sum of scores for the five items of the "10-item Constrain and Loneliness Questionnaire" suggestive of a constraint-type of threat that patients avoid
BH time (sec)	Duration of time that patients voluntary hold their breath
HV time (sec)	Duration of time that patients voluntary hyperventilated
Loneliness VAS story	Score in a VAS (0–100) for the 13-items of DSM-IV for panic attack that patients rated after they imagined a place or situation in which help might not be available if needed
Constriction VAS story	Score in a VAS (0–100) for the 13-items of DSM-IV for panic attack that patients rated after they imagined a place or situation in which escape is difficult
BH VAS	Score in a VAS (0–100) for the 13-items of DSM-IV for panic attack that patients rated after they voluntary hold their breath
HV VAS	Score in a VAS (0–100) for the 13-items of DSM-IV for panic attack that patients rated after they voluntary hyperventilated

Table 2. Correlation matrix from all variables entered in the analysis.

	Constriction scale	*Age*	*Gender*	*Loneliness VAS story*	*Constriction VAS story*	*BH VAS*	*HV VAS*	*BH time*	*HV time*
Loneliness	.42	–.19	–.26	.10	.35	–.06	.09	–.26	–.48*
Constriction scale		.03	.00	.30	.29	–.15	.20	–.46*	–.32
Age			.32	.05	–.29	–.21	–.17	.12	.17
Gender				.23	.20	.11	.26	–.24	–.05
Loneliness VAS story					.69**	.38	.21	–.35	–.34
Constriction VAS						.21	–.02	–.67**	–.47*
BH VAS							.32	.16	–.20
HV VAS								.43	–.33
BH time									.31
HV time									

with the duration of hyperventilation HV (r=–0.479, p<0.03). Since the HV-loneliness correlation is dependent to HV-constrain correlation a test of significant difference between dependent correlation was made but no significant difference was found (r= 0.749, p= 0.227)

Discussion

Although no discriminant validity was documented between the avoidance type (constrain and loneliness) and the scores of elicited anxiety responses by the mental and physical probes, the significant correlations found between a self report measure that is the responses of the constraint and loneliness questionnaires and the objective physiological measure of duration of hyperventilation and duration of breath holding argue in favor of the presumed hypothesis The fact that our sample primarily consisted of long standing cases of agoraphobia with a less prominent panic element, coupled with the application of physical probes under least- demanding conditions might be a sufficient explanation regarding the severity of the elicited symptoms. On the other hand, these "least demanding or threatening" challenges did favor the evaluation of the subjects' optimum capacity for BH or HV.

Thus, in our study we found that higher rating on "constraint" is correlated with a shorter BH duration and higher rating on "loneliness" is correlated with a shorter duration of HV. Both findings merit some comments: Zendbergen et al[13] found that BH duration is shorter in panic as well as in other anxiety disorders, compared to healthy volunteers. However, it has been reported that BH duration is not a reliable index of panic disorder,[14] and is shorter in panic disorder than in Generalized Anxiety Disorder.[15] Furthermore, McNally & Eke[16] and Eke & McNally[17] found that the duration of BH could not reliably predict the levels of anxiety in students. In brief, while the duration of BH seems to be shorter in patients with anxiety disorders than healthy volunteers, the specificity of this index is not further differentiated among the anxiety disorders, or between panic disorder and the other anxiety disorders. Among PD patients shorter BH after caffeine challenge was recorder in patients with more severe baseline psychopathology (Masrrakis et al[18]) Our findings may reconcile some discrepancies: shorter BH duration might hold true only for those patients that score high on items related to "constraint-type" of threats. It is therefore possible that the exposure to a constraint threat such as BH may trigger its corresponding inner schema representations that forced patients regardless of their diagnostic category - to stop this procedure earlier.

Regarding HV, Clark and Hemsley[19] found that HV causes many symptoms similar to the ones appearing during a panic attack, Bonn et al[20] found that 67% of patients with agoraphobia and panic attacks were not in a position to finish a HV test (60 breaths/min for 3 minutes) as opposed to 4% of the healthy volunteers. Telch et al[21] reported that duration of hyperventilation significantly predicted agoraphobia status among panic disorder patients even after controlling for differences in demographic and clinical characteristics. But, while HV is a well known panic- inducing clinical and research probe, in our study this test seems to be a sensitive probe for those agoraphobic patients that

scored higher on items related to "loneliness-type" of threat. Thus, the patients with an excessive "loneliness-type" schema behaved like the typical panic patients, in comparison to those having an excessive "constraint" schema. It is possible that the activation of the "loneliness" schema may have led patients to stop hyperventilation in order to avoid bigger exposition to non controllable symptoms.

Assuming that our questionnaire taped the "loneliness" and "constraint" schema threat, our hypothesis derived from Guidano & Liotti's assumptions was partially confirmed. However, the findings and the conclusions of the present study should be considered as preliminary, due to its several limitations such as the small number of patients, the lack of a control group, and the, as yet not definitely standardized, "10-item Constrain and Loneliness Questionnaire". Clinical implications from the empirical confirmation of Guidano & Liotti's assumptions will be mainly in psychotherapeutic practice. Agoraphobic patients should be able to recognize the relationship between heir "need for freedom" and their inner constrain-loneliness constructs and therapy should eventually aim at modifying those schemata.

In order to further test our hypothesis, a more comprehensive series of valid stimuli for the presumed schemata in conjunction with more sensitive recording methods of cognitive, emotional, somatic and behavioral responses are needed.

If verified, our hypothesis will be consistent with the revision supported in DSM-5 (Wittchen et al[22]) that Agoraphobia should be conceptualized as an independent disorder with more specific criteria rather than a subordinate, residual form of PD.

APPENDIX

"10-ITEM CONSTRAIN AND LONELINESS QUESTIONNAIRE"

Name	*Age*
Date	

Please indicate the degree to which you avoid the following places or situations because of discomfort or anxiety. Read carefully and rate your amount of avoidance when you are alone.

	Avoidance	*Rating (%)*
1	Never	0
2	Rarely	25
3	About half of the time	50
4	Most of the time	75
5		100

	Avoid	*0*	*25*	*50*	*75*	*100*
1	Crossing the center of an empty square	( )	( )	( )	( )	( )
2	Staying at home alone	( )	( )	( )	( )	( )
3	Going to crowded social and religious gatherings (church-wedding, visit etc)	( )	( )	( )	( )	( )
4	Walking alone on deserted streets	( )	( )	( )	( )	( )
5	Driving or riding a car in a traffic jam	( )	( )	( )	( )	( )
6	Being far away from home	( )	( )	( )	( )	( )
7	Going to a crowded theater	( )	( )	( )	( )	( )
8	Standing in the center of gatherings (political, athletic etc)	( )	( )	( )	( )	( )
9	Being far from medical care	( )	( )	( )	( )	( )
10	Sitting in the center of a crowded restaurant or cafeteria	( )	( )	( )	( )	( )

Εγκλωβισμός και μοναξιά στην αγοραφοβία: Εμπειρική διερεύνηση

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Οι ερευνητικές προσπάθειες διερεύνησης της αιτιοπαθογένειας της Αγοραφοβίας υπολείπονται συγκριτικά με τις προσπάθειες για τη διερεύνηση του Πανικού. Οι Guidano & Liotti έχουν προτείνει θεωρία για την Αγοραφοβία η οποία δεν έχει μελετηθεί επαρκώς. Οι συγγραφείς υποθέτουν την ύπαρξη των εσωτερικών αναπαραστάσεων φόβου «εγκλωβισμού» και φόβου «μοναξιάς» ως τα δύο μείζονα σχήματα που σχετίζονται άμεσα με την παθογένεση των εκδηλώσεων της Αγοραφοβίας. Η ενεργοποίηση των συγκεκριμένων σχημάτων επέρχεται σε συνθήκες στις οποίες ο ασθενής αισθάνεται: (α) παγιδευμένος, χωρίς διαφυγή (εγκλωβισμός) και (β) μόνος, απροστάτευτος ή αβοήθητος (μοναξιά). Η ενεργοποίηση του σχήματος εγκλωβισμού επιφέρει συμπτώματα όπως αίσθημα ασφυξίας, πόνο στον θώρακα, δυσκολία στην αναπνοή, κινητική ανησυχία, μυϊκή τάση ενώ η ενεργοποίηση του σχήματος μοναξιάς επιφέρει συμπτώματα όπως αίσθημα ταχυκαρδίας, αδυναμία, τρόμο ή αίσθημα κατάρρευσης. Η ενεργοποίηση αυτών των σχημάτων από ερεθίσματα συμβατά με αυτά αναμένεται να πυροδοτήσουν ποικίλα, αλλά διακριτά, είδη απαντήσεων τα οποία στο σύνολό τους περιγράφονται στην Αγοραφοβία. Η μελέτη στόχευσε στη διερεύνηση αυτής της θεωρίας και των κλινικών εφαρμογών που απορρέουν από αυτή. Σε 20 ασθενείς με Αγοραφοβία χορηγήθηκαν σωματικές και νοητικές δοκιμασίες και καταγράφηκαν οι απαντήσεις τους και η απόδοσή τους. Επιπλέον οι ασθενείς συμπλήρωσαν το «Ερωτηματολόγιο 10 λημμάτων για την Αγοραφοβία» το οποίο προτείνεται από την ομάδα μας ως κατάλληλο εργαλείο για την καταγραφή των γνωσιών εκείνων οι οποίες σχετίζονται με την έννοια του «εγκλωβισμού» και της «μοναξιάς». Ως σωματικές δοκιμασίες επελέγησαν το εκούσιο κράτημα της αναπνοής (ΚΑ) και η υπέρπνοια (Υ). Το ΚΑ επελέγη ως μια κλινική δοκιμασία η οποία με εύκολο τρόπο προκαλεί υπερκαπνοία και προσομοιάζει με την έννοια του «εγκλωβισμού». Ζητήθηκε από τους ασθενείς να κρατήσουν όσο το δυνατόν περισσότερο την αναπνοή τους και να διακόψουν τη δοκιμασία όταν αισθάνονταν ότι δεν μπορούν να συνεχίσουν πλέον. Η Υ θεωρήθηκε ότι προσομοιάζει με την έννοια της «μοναξιάς» αφού εκλύει συμπτώματα ζάλης, παραισθησίες, κρύα χέρια και πόδια, τρόμο, φαινόμενα δηλωτικά συμπτωματολογίας τύπου καταρρεύσεως. Οι απαντήσεις των ασθενών καταγράφηκαν ενώ υπήρχε συνεχής παρακολούθηση του καρδιακού και αναπνευστικού ρυθμού. Τα συμπτώματα που εκλύθηκαν από τα ερεθίσματα στο σύνολό τους δεν διαφοροποιήθηκαν μεταξύ τους. Σημαντική όμως συσχέτιση καταγράφηκε μεταξύ της διάρκειας των φυσικών δοκιμασιών και της βαθμολόγησης του «Ερωτηματολογίου 10 λημμάτων για την Αγοραφοβία». Η χρονική διάρκεια του ΚΑ συσχετίστηκε αρνητικά ($r=-0,456$, $p<0,05$) με τη βαθμολογία των 5 λημμάτων εγκλωβισμού του ερωτηματολογίου ενώ η χρονική διάρκεια της Υ συσχετίστηκε αρνητικά ($r=-0,479$, $p<0,03$) με τη βαθμολογία των 5 λημμάτων μοναξιάς του ερωτηματολογίου. Συνεπώς, με την προϋπόθεση ότι το ερωτηματολόγιο αναπαριστά το σχήμα απειλής εγκλωβισμού και μοναξιάς, η θεωρία των Guidano & Liotti εν μέρει επιβεβαιώνεται.

Λέξεις ευρετηρίου: Αγοραφοβία, εγκλωβισμός, μοναξιά, εκούσιο κράτημα της αναπνοής, υπέρπνοια.

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Research article
Ερευνητική εργασία

Agomelatine augmentation in obsessive compulsive disorder: A preliminary report

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Obsessive-compulsive disorder (OCD) is often the anxiety disorder that affects approximately 2% of the population. This disorder is associated with significant morbidity and dysfunction, and is included in the World Health Organization list of the ten most disabling medical illnesses. The therapeutic response of patients with OCD is relatively poor compared with that of other mental disorders. Pharmacological interventions for OCD have focused on modulating primarily serotonin function and secondarily dopamine neurotransmission. Augmentation treatment has been the subject of several studies in treatment-resistant obsessive compulsive disorder (OCD). We hypothesized that medications with a dual action on the melatoninergic and serotoninergic systems may be of use in treatment-resistant OCD. In this open label study we investigated the efficacy and safety of agomelatine augmentation in treatment-resistant OCD. Twelve patients, aged 18–50, fulfilling OCD criteria, having failed to respond to adequate treatment with a Serotonine Reuptake Inhibitor for at least 16 weeks, were assigned to receive agomelatine augmentation. Subjects were assessed with the Yale-Brown Obsessive Compulsive Scale (Y-BOCS), and were screened for treatment-emergent side effects at baseline and week 16 of treatment. We excluded patients with comorbid psychopathology, serious medical comorbidity, current or past history of substance abuse and severe personality disorders as well as patients receiving psychotherapy in addition to psychopharmacological treatment. Agomelatine augmentation lead to net improvement in Y-BOCS and its obsession and compulsion subscales after 16 weeks of treatment (all $p<0.005$). Agomelatine augmentation was well-tolerated and none of the patients dropped-out. Treatment-related adverse events were recorded as follows: (n, %): nausea: 1 (8.3%), headache 4 (33.3%), dizziness: 3 (25%) and somnolence: 2 (16.7%). The present case series study has several limitations due to its open-label design and the absence of a placebo or active control group. The small number of patients further limits the impact of our findings. The present case series study

showed that a 16 week add-on treatment with agomelatine, achieved on average a 25% improvement in Y-BOCS in refractory to treatment OCD patients; side effects were mild, and none of the patients dropped out throughout the 16-week study period. Agomelatine could be efficacious and well tolerated as an augmenting agent in refractory to treatment OCD. The unique pharmacological profile of agomelatine and its dual action on serotoninergic and melatoninergic receptors may be of interest in this difficult-to-treat illness. Further controlled studies are warranted to explore the efficacy of agomelatine, as well as the potential role of circadian rhythm modulation both in the pathophysiology and treatment of OCD.

Key words: Agomelatine, augmentation, obsessive compulsive disorder.

Introduction

Obsessive-compulsive disorder (OCD) is often a debilitating anxiety disorder that affects approximately 2% of the population.[1]

Characterized by recurrent anxiety-laden thoughts, images or impulses (obsessions) and accompanying behavioral or mental rituals (compulsions) meant to abate anxiety, the disorder is associated with significant morbidity and dysfunction, and is included in the World Health Organization list of the ten most disabling medical illnesses.[2]

The therapeutic response of patients with OCD is relatively poor compared with that of other mental disorders. Although symptom reduction by 20–40% is considered as satisfactory in most treatment trials, many responders remain markedly symptomatic;[3] consequently, novel therapeutic strategies are urgently needed.

Pharmacological interventions for OCD have focused on modulating primarily serotonin function and secondarily dopamine neurotransmission.[4] Medications that increase serotoninergic neurotransmission constitute the cornerstone of OCD pharmacotherapy.[5] However, 40–60% of OCD patients do not respond adequately to therapy with serotonin reuptake inhibitors (SRIs), and an even greater proportion of patients fail to achieve complete remission of their symptoms and therefore continue to experience significant impairment from their residual OCD symptoms.[3] Augmentation strategies with antipsychotics, buspirone and lithium are common practice either in patients with treatment-refractory OCD or in cases with psychiatric comorbidity, which is relatively common in OCD.[6]

Recent clinical studies have implicated also melatoninergic dysfunction in the pathophysiology of OCD, and preliminary data support the usefulness of augmentation with a melatoninergic agent in treatment-resistant OCD patients; consequently, investigators underline the need for more and larger trials.

We hypothesized that medications which resynchronize and attenuate melatoninergic activity (with a concurrent role in serotonin function) may be of benefit in the treatment of SRI-resistant OCD.[7–9] The objective of this open label case series study was to determine the efficacy and safety of agomelatine augmentation in treatment-resistant OCD.

Material and method

Over a calendar year we followed closely twelve outpatients (mean age±SD: 28.4±6.5 years) with treatment-resistant OCD. To be included in this case series the patients had to be 18–50 y.o., fulfilling the DSM-IV-TR OCD criteria, having failed to respond to adequate treatment with a SRI (SSRIs, venlafaxine or clomipramine) for at least 16 weeks. Moreover, they all had to show less than 25% score reduction on the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) following SRI treatment and a score ≥18 on the Y-BOCS.[10] We excluded patients with comorbid psychopathology, serious medical comorbidity, current or past history of substance abuse and severe personality disorders as well as patients receiving psychotherapy in addition to psychopharmacological treatment. Evaluation included the Mini-International Neuropsychiatric Interview (used to document the presence of OCD and comorbid conditions), the Y-BOCS (used for the assessment of severity of OCD symptoms and treatment response) and the Systematic Assessment for Treatment Emergent Events scale (SAFTEE; to assess safety and tolerability of treatment);[11] spontaneous reports or observed adverse events were recorded regarding time of onset,

duration and severity. All the patients underwent a routine laboratory screening according to the SPC and clinical side effects screening test. The study was approved by the in-hospital human subjects ethics board and was conducted in accordance with the Helsinki Declaration of 1975, as revised in 2000; written informed consent was obtained from all the included patients.

Agomelatine 25 mg/day with an increase to 50 mg/day after two weeks was added to the existing OCD regimen. Assessments were performed at baseline and after 16 weeks of treatment (end of the study).

Statistical analysis

The Wilcoxon signed rank sum test was applied to compare baseline and end Y-BOCS scores using SPSS v. 17 (SPSS Inc, Chicago, IL, USA).

Results

Mean score ± SD on the Y-BOCS and its two subscales as well as distribution of scores at baseline and after 16 weeks of treatment are shown on table 1. Agomelatine augmentation lead to net improvement in Y-BOCS and its obsession and compulsion subscales after 16 weeks of treatment (all $p<0.005$). Agomelatine augmentation was well-tolerated and none of the patients dropped-out. Treatment-related adverse events were recorded as follows: (n, %): nausea: 1 (8.3%), headache 4 (33.3%), dizziness: 3 (25%) and somnolence: 2 (16.7%).

Discussion

The present case series study showed that a 16 week add-on treatment with agomelatine, achieved on average a 25% improvement in Y-BOCS in refractory to treatment OCD patients; side effects were mild, and none of the patients dropped out throughout the 16-week study period.

Augmentation has been the subject of several studies on treatment-resistant OCD Augmentation strategies in obsessive-compulsive disorder.[12] In general, the addition of a low dosage antipsychotic to an SSRI should be considered if all other approaches have failed, i.e., attempts with various SSRIs and cognitive behavioural psychotherapy. Lithium, anticonvulsants, buspirone and ECT have been widely investigated, especially when comorbid conditions exist. Our study supplements and extends the findings of Fomaro et al[13] who demonstrated the efficacy of agomelatine monotherapy in a switch study in SRI-resistant OCD patients with comorbid anxiety and affective disorders. In our study, OCD patients without comorbid psychiatric disorders were enrolled, with a relatively higher Y-BOCS score upon entering the trial.

Although agomelatine's efficacy in the treatment of major depressive disorder has been widely investigated, there are limited data regarding its potential role in the management of OCD. Agomelatine's mode of action through 5-HT_2C modulation and subsequent norepinephrine and dopamine firing disinhibition at the prefrontal cortex, as well as the influence of MT_1 and MT_2 agonism on circadian rhythms, might suggest a potential role of agomelatine in the management of anxiety disorders, including OCD.[7,13] In addition, side effects associated with agomelatine augmentation, i.e., dizziness, headache, somnolence and nausea, were mild, subsided within a few days and none of the participants dropped out of the study.

Limitations

The present case series study has several limitations due to its open-label design and the absence of a placebo or active control group. The small number of patients further limits the impact of our findings. Moreover, the duration of a therapeutic trial with a SRI, prior to augmentation with agomelatine, should be of an adequate dose and duration, since the response to anti-OCD medications is relatively slow, while there is evidence that patients continue to improve even after a 12-week period. To tackle this point in our study, we ensured that all participants received antidepressants at an adequate dose for at least 4 months prior to entry.

In conclusion, this study suggests that agomelatine as an add-on agent could be efficacious and well-tolerated in OCD patients refractory to treatment. The unique pharmacological profile of agomelatine and its dual action on serotoninergic and melatoninergic receptors may be of interest in this difficult-to-treat illness. Further controlled studies are warranted to explore the efficacy of agomelatine, as well as the potential significance of circadian rhythm modulation in both the pathophysiology and treatment of OCD.

Table 1. Efficacy result for twelve patients with obsessive-compulsive disorder who received augmentation as add-on therapy and completed the trial.

Patient Sex Age	*Antidepressant and dose (mg/day)*	*Baseline YBOCS total*	*Endpoint YBOCS total*	*Change YBOCS total (%)*	*Baseline YBOCS Obsession scale*	*Endpoint YBOCS Obsession scale*	*Change (%) YBOCS Obsession scale*	*Baseline YBOCS compulsion scale*	*Endpoint YBOCS compulsion scale*	*Change (%) YBOCS compulsion scale*
1 M 27	Citalopram 80	25	18	28	12	10	16.6	13	8	38.4
2 F 24	Flyvoxamine 300	23	19	17.3	13	11	15.3	10	8	20
3 F 36	Citalopram 80	24	20	16.6	9	8	11.1	15	12	20
4 M 28	Fluoxetine 60	21	11	45.6	12	5	58.3	9	6	33.3
5 M 29	Sertraline 250	22	12	45.4	11	7	36.3	11	5	54.5
6 M 44	Flyvoxamine 250	20	16	20	8	7	12.5	12	9	25
7 F 32	Venlafaxine 300	20	18	10	12	12	0	8	6	25
8 M 19	Fluvoxamine 300	21	20	4.7	11	11	0	10	9	10
9 M 25	Paroxetine 60	24	15	37.5	14	8	42.8	10	7	30
10 M 26	Venlafaxine 375	22	14	36.3	10	6	40	12	8	33.3
11 M 28	Sertraline 300	20	19	5	12	12	0	8	7	12.5
12 M 23	Fluoxetine 60	21	13	33.3	13	6	53.4	8	7	12.5
				(24.9%)			23.8%			26.2%
	Mean±SD	21±1.7	16.2±3.1		11.4±1.7	8.5±2.5		10.5±2.1	7.6±1.8	
	p	0.002			0.007			0.002		

M: male, F: female

Ενισχυτική θεραπεία με αγομελατίνη σε ανθεκτική ιδεοψυχαναγκαστική διαταραχή: Προκαταρκτική μελέτη

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Η ιδεοψυχαναγκαστική διαταραχή είναι συχνά η αγχώδης διαταραχή που επηρεάζει το 2% του πληθυσμού. Η διαταραχή αυτή συνδέεται με σημαντική νοσηρότητα και δυσλειτουργία, και περιλαμβάνεται από τη Παγκόσμια Οργάνωση Υγείας στη λίστα των δέκα ασθενειών που καθιστούν περισσότερο από τις υπόλοιπες ανίκανο τον ασθενή. Η θεραπευτική ανταπόκριση των ασθενών με ιδεοψυχαναγκαστική διαταραχή είναι σχετικά φτωχή σε σύγκριση με εκείνη των άλλων ψυχικών διαταραχών. Οι φαρμακολογικές παρεμβάσεις για την ιδεοψυχαναγκαστική διαταραχή έχουν επικεντρωθεί κυρίως στη λειτουργία και δράση της σεροτονίνης, και δευτερευόντως στη νευροδιαβίβαση της ντοπαμίνης. Η ενίσχυση της ανθεκτικής θεραπείας της ιδεοψυχαναγκαστικής διαταραχής έχει γίνει αντικείμενο μελέτης αρκετών ερευνών. Ως υπόθεση θεωρούμε ότι τα φάρμακα με διπλή δράση στο σεροτονινεργικό καθώς και στο μελατονινεργικό σύστημα μπορούν να χρησιμοποιηθούν στους ανθεκτικούς στη θεραπεία ιδεοψυχαναγκαστικούς ασθενείς. Σε αυτή τη μελέτη ελέγχουμε την αποτελεσματικότητα και την ασφάλεια της αγομελατίνης ως ενίσχυση της θεραπείας ανθεκτικών ιδεοψυχαναγκαστικών ατόμων. Το δείγμα περιελάμβανε 12 ασθενείς, ηλικίας 18–50 ετών, που πληρούσαν τα κριτήρια της ιδεοψυχαναγκαστικής διαταραχής, οι οποίοι δεν ανταποκρίθηκαν σε επαρκή θεραπεία με αναστολείς επαναπρόσληψης σεροτονίνης για ένα διάστημα τουλάχιστον 16 εβδομάδων και έλαβαν ως ενίσχυση της θεραπείας τους αγομελατίνη. Οι ασθενείς αξιολογήθηκαν με τη Yale-Brown Ιδεοψυχαναγκαστική Κλίμακα (Y-BOCS), και επιπλέον έγινε έλεγχος για παρενέργειες του φαρμάκου στην έναρξη της χορήγησης και στη 16η εβδομάδα της θεραπείας. Αποκλείσθηκαν ασθενείς με συννοσηρότητα είτε με άλλη ψυχική νόσο είτε με άλλη σοβαρή σωματική ασθένεια, ασθενείς με ιστορικό κατάχρησης ουσιών ή και κατάχρηση ουσιών κατά την περίοδο της έρευνας, ασθενείς με σοβαρή διαταραχή προσωπικότητας, καθώς και εκείνοι που πέρα από φαρμακευτική αγωγή είχαν τεθεί και σε ψυχοθεραπεία. Η ενίσχυση της θεραπείας με αγομελατίνη οδήγησε σε μια ξεκάθαρη βελτίωση στη Y-BOCS κλίμακα και τις υποκλίμακες αυτής που αφορούν τις ιδεοληψίες και τους καταναγκασμούς μετά τις 16 εβδομάδες θεραπείας (όλες $p<0,005$). Η ενίσχυση της θεραπείας με αγομελατίνη ήταν καλά ανεκτή και κανένας ασθενής από το δείγμα δεν εγκατέλειψε τη μελέτη. Οι παρενέργειες σχετιζόμενες με τη θεραπεία καταγράφηκαν ως εξής (n, %): ναυτία 1 (8,3%), κεφαλαλγία 4 (33,3%), ζάλη 3 (25%) και υπνηλία 2 (16,7%). Η παρούσα μελέτη έχει διαφόρους περιορισμούς λόγω του σχεδιασμού της και της έλλειψης εικονικού φαρμάκου ή ομάδας ελέγχου. Ο μικρός αριθμός των ασθενών επίσης περιορίζει τη βαρύτητα των ευρημάτων μας. Η παρούσα μελέτη κατέδειξε ότι η ενισχυτική θεραπεία 16 εβδομάδων με αγομελατίνη οδήγησε σε βελτίωση κατά 25% στους ανθεκτικούς ιδεοψυχαναγκαστικούς ασθενείς. Οι ανεπιθύμητες ενέργειες ήταν ήπιες και κανείς από τους ασθενείς δεν εγκατέλειψε τη μελέτη. Η αγομελατίνη πιθανώς θα μπορούσε να είναι αποτελεσματική και καλά ανεκτή ως προσθήκη σε ανθεκτική στη θεραπεία ιδεοψυχαναγκαστική διαταραχή. Το ιδιαίτερο φαρμακολογικό προφίλ της αγομελατίνης με τη διπλή δράση στους σεροτονινεργικούς και μελατονινεργικούς υποδοχείς μπορεί να χρησιμεύσει στις περιπτώσεις αυτές. Περαιτέρω μελέτες είναι αναγκαίες προκειμένου να διερευνηθεί ο ρόλος της αγομελατίνης τόσο στην παθοφυσιολογία όσο και στη θεραπεία της ιδεοψυχαναγκαστικής διαταραχής.

Λέξεις ευρετηρίου: Αγομελατίνη, ενίσχυση θεραπείας, ιδεοψυχαναγκαστική διαταραχή.

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Special article
Ειδικό άρθρο

Child is father of the man: Child abuse and development of future psychopathology

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Available epidemiological data indicate that the abuse of children within families is a very common phenomenon, and is still on the rise. Among others, abuse includes direct physical and emotional violence to the child, as well as the indirect emotional trauma of witnessing interparental violence. These early trauma experienced within the context of the family can influence the development of the child's personality as well as predispose towards the development of mental disorders in adulthood. There are some important factors influencing the occurrence of abuse, or the conditions predisposing it: certain parental personality traits appear to be instrumental, and the presence of individual psychopathology of parents is also connected with different forms of family dysfunction as a system, representing a variable which is interpolated in the quality of parenthood as the most important factor that determines long-term consequences on children and possible future psychopathology. The complex but tangible effects of parents' personality traits on the psychological development of children may contribute to the transgenerational transmission of abuse and violence. The phenomenon of domestic violence and abuse can be described from the perspective of the psychological and systemic theoretical postulates. According to systemic theory and practice, dysfunctional communication in the family is a significant predictor for domestic violence. Characteristics of dysfunctional communication include low levels of verbal expressiveness and emotional responsiveness, low tolerance to criticism and its interpretation as a threat or intimidation, and consequently increased anxiety and subsequent escalation of an argument into violence. Overall it seems that there may be a complex connection between parental personality and family interaction patterns, leading to dysfunctional com-

munication which further amplifies the detrimental characteristics of family dynamics, and eventually escalates to violence. According to one theory, there may be a degree of transgenerational transmission of these communication patterns in children who have been victims of violence, thus propagating the conditions for violence, this time perpetrated by the victims themselves. Therefore there is a pressing need for prevention, perhaps through psychoeducation for parents or through early detection and treatment of traumatized children and adolescents, in the hope that the transgenerational vicious cycle of violence may be broken

Key words: Child abuse, parenting, family system, family violence, psychopathology, transgenerational transmission.

Introduction

Despite the widespread myth of the family being "a safe place", available epidemiological data indicate that the risk of violent victimization is very high in the context of family relations. Child abuse is, besides traffic accidents, the leading cause of morbidity and mortality among children.[1] It is also well known that traumatic experience of child abuse has a significant impact on the psychological, physical and social functioning and development of a child. It was shown that 25% of women and 8% men experienced physical or sexual abuse perpetrated by their spouse or partner during their lifetime and that 30% of children are witnessing repeated scenes of violence among their parents, which could represent a form of emotional child abuse.[2] The incidence of physical child abuse is about 5.7 per one thousand children, and it is on the rise, whereas the incidence of physical and emotional neglect, as well as emotional abuse is much higher.[3] It is important to note that research of emotional abuse is somewhat neglected, and in comparison to data available about physical abuse, this data are more limited.

The data regarding child abuse and neglect in Serbian families are scarce. In one of few studies conducted 0.7% of the examined subjects stated that scenes of domestic violence are very common, while 7.3% of parents reported that violence occurs from time to time, and that children generally witness these scenes.[4] So, unfortunately, the years of childhood are not always magic but can be full of "sound and fury". According to the research carried out by the Unit for protection of children against abuse and neglect at the Institute of Mental Health in Belgrade, during 2000–2011, there were 734 reported cases of child and adolescent abuse and neglect[5] – only 11.3% were referred to a psychiatrist primarily for abuse and neglect, significantly smaller percentage of children (2.5%) came directly or was referred to the Institute primarily for psychiatric problems with already registered abuse and/or neglect, and the largest number of cases (86.2%) was first discovered during the child's psychiatric treatment at the Institute.

The phenomenon of family violence and abuse has only recently become multidisciplinary. From the sociological perspective, there is discussion on the historical-sociological legitimacy of the phenomenon of family violence in the context of cultural specificities, enumerating belief in "the privacy" of violence in the family, and the gender inequality related to the issue.[6] The majority of studies, however, focus on research of the psychological impact of traumatic experiences, such as abuse, on the personality development, as well as on the characteristics of personality traits of an abuser. In recent times, studies of family therapists focused on specific characteristics of family communication patterns and interaction in families where there is violence and abuse.[2] In this paper, we will address the phenomenon of domestic violence and abuse from the perspective of psychological and systemic theoretical postulates.

Child abuse and personality development

The idea that early traumatic experience in the family can influence personality development, as well as different forms of psychopathology in the adulthood, was developed by early psychoanalysts. "The child is father of a man", was said in William Wordsworth's beautiful poem "The Rainbow" and that was one of the central topics of Freud's theory.

As the theories about the development of psychopathology were becoming more complex, it became clear that direct correlation of these factors represents a simplification of the complex phenomenon of early trauma. According to some psychoanalysts the intra-psychological processing of experiential content could be more important than the actual experience in early age, while cognitive-behavioral theorists highlight the importance of processing life experiences.[7] The theoreticians of family therapy, however, suggest that the development of psychopathology emerges in the context of subtle, but permanent factors that influence the individual, such as long-term dysfunction of the family structure.[8] Family dysfunction adversities present the most consistent association between chronic adversity and psychopathology and their impact is considered non-specific with regard to the type of disorder.[9] According to the multidimensional model development of a disorder, it is the result of a complex interaction of constitutional factors with psychological risk factors, pointing out to an interaction between "emotional vulnerability" and dysfunctional family environment.[10]

The studies of childhood traumatic stress imply the existence of frequency of early trauma in persons who develop a psychiatric disorder, especially personality disorders, which has prompted research on long-term effects of early trauma on the personality development.[11] Traumatic experiences related to childhood can influence development of disorders in the perception of one's body, difficulty in establishing trust, intimacy and self-confidence, as well as the development of a negative experience of one's "self".[12] The findings indicate that persons who have been victims of abuse during childhood, often develop patterns of avoidance or ambivalence towards emotional bonding,[12] which makes difficult to establish close relations with others in adult age, especially in the sphere of partner relationships. The persons who experienced early trauma often develop self-defeating strategies for overcoming stress[13] and auto-destructive attitudes and patterns of behavior.[14] Victims of childhood sexual abuse have eight times higher risk of repeated suicide attempts,[15] while parental perpetration of sexual abuse increases the likelihood of multiple suicide attempts among women outpatients.[16] Some studies confirm that adolescents are especially vulnerable, and that there is a high correlation between physical abuse in the childhood and the risk of suicidal behavior, as well as an auto-destructive attitude in adolescence.[17] Suicide attempts before 18 years of age increase with repeated maltreatment of adolescents.[18]

There are certain differences in the manifestation of consequences depending on the time when the trauma occurred.[19] Adult victims of sexual abuse manifest less trust in others, problems in sexual functioning, and poor emotional expressiveness, while victims of sexual abuse during childhood develop cognitive dysregulation, affective instability, identity disorder and problems in the interpersonal domain. An important correlation is observed between these manifestations and the basic clinical characteristics of severe personality disorders.[20]

The quality of parenthood and development of psychopathology

The impact of trauma, experienced in the family setting is considered to be related to various mental disorders, such as personality disorders,[21] especially borderline personality disorder (BPD),[22] eating disorders,[23] substance abuse[24] and schizotypal personality disorder.[25] Furthermore, depression and social introversion can be developed in the individuals that have grown up in families where physical, emotional and sexual abuse occurred.[26] The trauma of early childhood abuse and neglect are significant in development of the BPD[27] and sexual abuse is considered to be a significant etiological factor in over 60% of patients with this disorder.[28] Repeated traumatic experiences are related to development of borderline pathology, causing comorbidity of BPD and post-traumatic stress disorder.[29–31]

It was shown that the victims of sexual abuse have experienced a high degree of conflicts and a low level of cohesion in their families[32] as well as that abusive and neglectful parenting is determinant of adult mental illness.[20] The severity of personality disorder correlates with the conflicting family environment and the abusive pattern in parent-child relation.[33]

It seems that personality traits of parents and their individual psychopathology are connected with different forms of family dysfunction as a system, representing a variable which is interpolated in the complex dysfunctional patterns of family functioning. The quality of parenthood is probably the most important factor that determines long-term consequences on children's mental health.[20] The majority of children with manifest physical aggressiveness and lacking in socially acceptable manners of channeling aggression originate from families in which mothers had antisocial behavior during childhood.[34] Furthermore, it has been shown that younger mothers are more prone to abuse their children, especially when they have personal history of abuse.[35] However, some studies have shown that paternal and maternal characteristics (such as locus of control, or emotional distress) that predate the birth of a child are related to later behavioral outcomes in child.[36]

It seems that persons with personality disorders enter into the parental and partner relationship, bringing the burden of a deficient and often pathological early development. It contributes to the phenomenon of trans-generational transmission of patterns of abuse, where the abused child in the adult age may become an abuser.[37]

Studies focused on the quality of parenthood and the dysfunctional psychological development of children, have shown that antisocial personality traits among males are related to lower maternal care and higher level of parental restrictions during childhood, while antisocial traits among females are related to lower paternal care, and negation of autonomy carried out by the mother.[38] Over-protectiveness by the father significantly correlates with neuroticism and depression among males, while maternal neglect is significantly related to depression and self-criticism among females.[39] Lower levels of parental care and high levels of intrusiveness are connected to development of certain aspects of the temperament, such as lower self-directedness and distinct patterns of avoiding uncomfortable stimuli.[38]

Systemic perspective of family violence

Researchers of the systemic theory and practice point out the importance of dysfunctional communication process in families, finding them to be more significant predictors of domestic violence than the personal and socio-demographic characteristics.[40] It was shown that violence against children or partner has the function of establishing control, and presents a type of interactive communication. Abusive parents often have rigid expectations regarding children behavior, which they usually reinforce by corporal punishment, creating and maintaining a vicious circle of behavioral patterns in the family.[40] Studies, furthermore, depict deficiency in communication skills in families with violence. Abusive parents have less empathy, lower level of verbal expressiveness and weaker impulse control.[41] It was shown that violent parents and partners more frequently attribute hostile and negative intentions to actions and words from other family members, and react with a "counterattack" demonstrating aggression.[42] In nonviolent families negative feelings are the most frequent reactions to disagreement and criticism, while violent parents or partners react by stopping interactions and personal emotional responses, because they interpret the content as threatening or intimidating. This, consequently, creates higher levels of anxiety in the relationship and augments the risk of escalation into a violent act.[42] It is considered that there is a mutual connection between dysfunctional patterns of interaction within family and their consequences.

Violence is considered to be caused by dysfunctional patterns of communication, and as a consequence of specific interaction, which have reverse effect on the family functioning. It has been shown that children, victims of family abuse, demonstrate less verbal communication skills and weaker social competency in the adult age, which might be a risk of developing antisocial behavior[42] as well as of the problems in partner relationships. Establishing long-term close relationships for these people is very difficult. One of the reasons for this is the acquired pattern of interpretation of the content of communication, which includes interaction with people outside the family, whose intentions are perceived as hostile. Studies emphasize the connection between violent behavior in partner relationships and negative interactions with parents in childhood, as well as corporal punishment by parents.[43]

Because of all that, the Belgrade Institute of Mental Health has unique departments collaborating with different sectors (social care, justice, schools, etc): the Unit for protection of children against abuse and neglect, Unit for treatment of people accused for domestic violence (referred by Department of Justice), Department for couple and family treatment) as well as continuous education on healthy parenthood.

Conclusion

It seems that there is a complex connection between personality, family interactions patterns and violence. Communication skills, closely related to the parent`s or partner`s personality traits, processes of interpretation which give meaning to events and communication content, emotional reactions and styles of interaction which are consequently established, are connected in a complex, mutually dependent way, with a risk of violence and family abuse. On the other hand, once established, violent patterns in the family are amplified and maintained, deeply compromising communication between family members and family functionality, creating conditions for dysfunctional personality development of children. Therefore, preventive strategies such as education of healthy parenthood as well as early detection and treatment of children and adolescents who had traumatic experiences are some of the most important activities of mental health care workers. It is important for future generation of adults and for breaking up the spiral of violence and its trans-generational transmission.

Το παιδί είναι ο πατέρας του ανδρός: Παιδική κακοποίηση και μελλοντική ανάπτυξη ψυχοπαθολογίας

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Διαθέσιμα επιδημιολογικά δεδομένα δείχνουν ότι η ενδο-οικογενειακή παιδική κακοποίηση είναι ένα πολύ συχνό φαινόμενο που εξακολουθεί να βρίσκεται σε άνοδο. Μεταξύ άλλων, η κακοποίηση περιλαμβάνει τη σωματική και συναισθηματική βία στο παιδί, καθώς και το έμμεσο συναισθηματικό τραύμα που προκαλείται όταν το παιδί γίνεται μάρτυρας διαγονικής βίας. Οι πρώιμες ενδοοικογενειακές τραυματικές εμπειρίες μπορούν να επηρεάσουν την ανάπτυξη της προσωπικότητας του παιδιού, καθώς και την εμφάνιση ψυχικών διαταραχών στην ενήλικη ζωή. Υπάρχουν μερικοί σημαντικοί παράγοντες που επηρεάζουν την εμφάνιση της κακοποίησης και τις συνθήκες που την προδιαθέτουν: Καθοριστικής σημασίας φαίνεται να είναι τα χαρακτηριστικά της προσωπικότητας των γονέων και η παρουσία ψυχοπαθολογίας στους γονείς, τα οποία συνδέονται με διάφορες μορφές συστημικής δυσλειτουργίας της οικογένειας, και αντιπροσωπεύουν μια παράμετρο που κατ' επέκταση συνιστά την ποιότητα της γονικής λειτουργίας ως τον πιο καθοριστικό παράγοντα για τις μακροπρό-

θεσμες συνέπειες για τα παιδιά και για τις πιθανές μελλοντικές τους ψυχοπαθολογίες. Η πολύπλοκη, πλην απτή, επίδραση των χαρακτηριστικών της προσωπικότητας των γονέων στην ψυχολογική ανάπτυξη των παιδιών μπορεί να συμβάλει στη διαγενεακή μετάδοση του φαινομένου της κακοποίησης και της βίας. Το φαινόμενο της ενδοοικογενειακής βίας και της κακοποίησης μπορεί να περιγραφεί μέσω της ψυχολογικής και συστημικής θεώρησης. Σύμφωνα με τη συστημική θεωρία και πράξη, η δυσλειτουργική επικοινωνία στην οικογένεια αποτελεί έναν σημαντικό προγνωστικό παράγοντα για την ενδοοικογενειακή βία. Μεταξύ των χαρακτηριστικών της δυσλειτουργικής επικοινωνίας περιλαμβάνονται τα χαμηλά επίπεδα λεκτικής εκφραστικότητας και συναισθηματικής απόκρισης, η μικρή ανοχή στην κριτική και η ερμηνεία αυτής ως απειλή ή εκφοβισμό, και κατά συνέπεια το αυξημένο άγχος και η επακόλουθη κλιμάκωση μιας διαφωνίας σε βία. Συνολικά, φαίνεται πως υπάρχει μια σύνθετη σχέση μεταξύ της προσωπικότητας των γονέων και των προτύπων αλληλεπίδρασης στην οικογένεια, που οδηγεί σε δυσλειτουργική επικοινωνία, η οποία εντείνει περαιτέρω τα επιβαρυντικά χαρακτηριστικά της οικογενειακής δυναμικής, και τελικά κλιμακώνεται σε βία. Σύμφωνα με μια θεωρία, ώς έναν βαθμό αυτά τα πρότυπα επικοινωνίας μεταδίδονται διαγενεακά σε παιδιά που έχουν πέσει θύματα βίας, και με αυτόν τον τρόπο διαιωνίζονται οι προϋποθέσεις της βίας, αυτή τη φορά με θύτες τα ίδια τα θύματα. Ως εκ τούτου, υπάρχει πραγματική ανάγκη για πρόληψη, ίσως μέσω ψυχολογικής εκπαίδευσης των γονέων ή μέσω έγκαιρης διάγνωσης και θεραπείας των παιδιών και των εφήβων που έχουν υποστεί ψυχολογικό τραύμα, με την ελπίδα ότι ο διαγενεακός φαύλος κύκλος της βίας μπορεί να σπάσει.

Λέξεις ευρετηρίου: Παιδική κακοποίηση, γονεϊκή συμπεριφορά, οικογενειακό σύστημα, οικογενειακή βία, ψυχοπαθολογία, διαγενεακή μετάδοση.

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Special article
Ειδικό άρθρο

Pseudologia fantastica à deux: Review and case study

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While lying is a diachronic integral part of human interaction, pseudologia fantastica represents probably its psychopathological dimension. There are relatively few reported cases on psychological mechanisms of pathological lying and also on criteria concerning psychopathological development on a ground of lying. A review of literature on possible psychological mechanisms of pseudologia fantastica is presented. Psychopathological qualities are rather controversial, especially whether pathological lying is a conscious act or not. DSM IV-TR recognizes pseudologia fantastica in association with factitious disorder but not as a clinical entity. Diagnostic issues are raised regarding lying, deception, pseudology and its shared dimension. Cases of shared pseudology are rarely reported in literature. Related shared psychopathological phenomena such as pseudologia à deux, folie à deux and mass hysteria are equally examined and compared under the prism of 'mental infection'. Cases of pseudologia fantastica are poorly understood or underecognized and clinicians usually pay minor attention in its psychopathological significance. It remains doubtful, whether pathological lying should be considered as an autonomous clinical entity. The need for research both on phenomenology and pathophysiology is emphasized. In addition to reviewing literature, we also report a case of pseudology à deux in a couple, a female and a male patient. Presented psychopathological manifestations, personality characteristics, psychological and social factors concerning both patients are considered, aiming to determine a sufficient phenomenological analysis. The diagnoses of pseudologia fantastica and folie à deux are discussed and documented. A second axis diagnosis of personality disorder and other diagnostic issues are also considered. A favorable issue of this case, within a follow up of one year, is due to the therapeutic and social potential of a community psychiatry's setting, offering an individual follow up to both partners and a family approach including the ex husband of the female patient and her two minor children. The presented case focuses on a notably rare and controversial form of pathological lying, pseudologia fantastica à deux, and possible underlying mechanisms.

Key words: Pseudologia fantastica, pseudologia à deux, folie à deux, mental infection, personality disorder, community psychiatry.

Introduction

Falsehood and deceit have universal spread, as they are self-defense mechanisms. Humans lie for many reasons and in many ways. Lies are more or less frequent, huge or small, altruistic or deliberate, obvious or subtle, intentional to specific goals or purposeless.[1] Children use lies and fantasy as a means of denial of reality and this is an important aspect of self-protection and personal development.[2] In adults, when lying behavior is repeated, persists or becomes disproportionate, then it may be considered as pathological. This phenomenon was described by the German psychiatrist D. Delbruck about a century ago, as "pseudologia fantastica".[3] Since then, other terms such as mythomania, morbid lie, pathological lying have been used.

Recent reviews of Dike[4] and Birch[5] attempt to identify the qualitative characteristics of pathological lying. Historically, we observe conflicting views among those who believe that reality testing is impaired in pathological liars – and in these cases falsehood may acquire a psychopathological dimension, a kind of "wish psychosis"[3] - and those who believe that pseudologia fantastica is a willful act, partially recognized – and in these cases pathological liars maintain a good reality control in other issues, a kind of “double consciousness” (actual and desired life run together).[3] A pathological liar may believe his lie to a degree that his belief can acquire a delusional character for the others, but he is able to recognize, at least in part, that his stories are not authentic, when questioned vigorously. However, it remains doubtful whether pathological lying is always a conscious act and whether pathological liars always have control over their own lies.

In cases of pathological lying, it is often difficult to distinguish between fantasy and reality, but lies do not have a delusional intensity or an organic etiology due to memory impairment. Liars have generally good judgment in other matters. A psychological cause is often unclear for pathological lies and can be attributed to intrinsic motivations (e.g. self management, wish fantasy-fulfillment) and only partially to externally determined ones (e.g. financial gain or legal-punishment avoidance). Lies in pathological liars are often unplanned and impulsive. The excessive, impulsive pseudologia usually begins in adolescence and often becomes chronic.[4,5]

From a psychoanalytic point of view, H. Deutsch considered pseudologia fantastica a daydream communicated as a reality.[6] The subject, escaping from reality, declines in daydreaming and imagination in order to resolve internal and external conflicts. Deutsch compares the significance of lying for a pathological liar to that of poetry for the poet, as it can be a gratification in itself, opposed to the (single or "daily") lie, which is usually goal-directed, for a determined reason.[7] In pathological lying, defense mechanisms of denial and repression may be partially recognized, but there is significant difference from other psychopathological conditions. Denial is a rather passive mechanism of defense, while in pseudology is actively involved in creating new mental conceptions.[6] In repression, especially in the hysteric type of neurosis, libido is withdrawn from the object, while in falsehood this is not the case, as the object is replaced by other acceptable objects and returns as a symptom following the pleasure principle.[6] Affects are manifested as tied to the surrogate object, while the relationship to the old (repressed) object has not been dissolved but continues in pseudology. Ford (1988)[1] summarizes some other internal mechanisms possibly involved in mendacity and includes autonomy, the need for self-esteem regulation, strength or aggression and wish fulfillment. Cyrulnic considers mythomania as an one hundred and eighty degrees reversal from non-expressed emotion and mental pain in fictional illusion.[8]

As far as neurobiological background is concerned, one study reported that 40% of the cases of pseudologia fantastica had a history of central nervous system abnormalities.[9]

Deutsch (1918) first reported and described a case of induced psychopathology respecting pseudologia fantastica.[10] She called it “shared pseudology” or “pseudology à deux” (1922),[6] as a clinical analog to “folie à deux”, with the difference that hysterical rather paranoid personality structures are involved in shared pseudology and daydreams expressed as falsehood rather than delusions or psychotic experiences are shared here. While the phenomenon has been described almost since a century, it has not been sufficiently studied and remains almost unknown among specialists, unlike folie à deux which has attracted great clinical attention.

The conception of "double insanity" in the form of "mental infection" was formulated initially, one and half century ago,[11] and several references followed thereafter. First, the authors agreed that "mental infection is a kind of involuntary mimicry and differs to submission as it occurs spontaneously". They pointed out the "mental superiority" of the primary affected individual to one or more than one secondarily "infected", their close, emotional and symbiotic association and the plausibility of emergence of psychopathological, delusional "seeds", with concomitant common emotional appeal.[12] Since then, extended reviews[13,14] have covered the time display range of the phenomenon. The role of psychological, social, demographic factors, previous individual psychiatric record, family history and specific elements of the relationship between primary and secondary affected person in the emergence of shared psychotic syndrome is thoroughly examined. If some risk factors such as passive personality traits, social isolation, adverse life events, cognitive impairment and language difficulties are excluded, there are insufficient findings in favor of distinct causal mechanisms possibly involved in the emergence of the phenomenon. Emphasis is placed on investigating possible presence of genetic vulnerability or preexisting disorder in the individual secondarily "infected" by a psychosis. It is assumed that in these cases the manifestation of induced psychopathology points out a psychotic syndrome that would have appeared anyway. In literature, there have also been described phenomena in which psychosis can "infect" a larger number of people (e.g. folie à famille).[15,16]

Another dimension of shared psychopathology concerns mass hysteria phenomena, which have long preoccupied the medical community. Mass hysteria, or otherwise epidemic hysteria, refers to a set of symptoms suggesting an unrecognizable organic disease, emerging in two or more persons, who share common beliefs on their symptoms. It may be considered as a social phenomenon that occurs in "healthy people" and is displayed by symptoms of anxiety and somatization (e.g. abdominal pain, dizziness, shortness of breath, nausea, headache) and motor symptoms (seizures, laughter, pseudoseizures, abnormal movements).[17] Epidemiological studies report an increased incidence of mass hysteria phenomena in groups of adolescents and children, in groups of women and generally in groups of people after exposure to severe stress or traumatic events and point out that they may spread rapidly through visual or narrative influence or the catalytic one of mass media. These symptoms are usually resolved after the separation of individuals who have experienced those common disorders and their removal from the aggravating environment.[17,18] Although outbreaks of mass hysteria occur repeatedly throughout history in various ethnic, religious, cultural groups,[17] there is no clear evidence on the pathophysiological dimension of the phenomenon. Recently, the involvement of the mirror neuron system was suggested.[19]

Diagnostic issues

It is not clear whether pathological lying can be considered as a separate psychiatric disorder. Literature does not elucidate whether it is a primary clinical entity, a symptom in the context of other major disorders or just a component of normal human behavior. In the field of clinical practice, pathological lying concerns mainly Forensic Psychiatry, because of the frequent concomitant legal issues. At present, pseudologia fantastica is recognized as a symptom in the DSM-IV-TR by the term of "falsification of physical or psychological signs or symptoms" and listed as one of the core features of Factitious Disorder. However, there is a clear correlation between cheating, feigning and pathological lying with other psychiatric conditions, such as malingering (where lying serves a defined purpose), confabulation (in the context of Korsakoff's syndrome), Ganser syndrome (where falsehood has a simple content and coexists with disorders of consciousness, secondary amnesia, hallucinations and sensory alterations) and cluster B personality disorders.[4] Specifically, in Antisocial Personality Disorder deception and repeated lies aim to personal gain or satisfaction, in Borderline Personality Disorder instable self-identity, defense mechanisms of primitive denial, idealization and devaluation offer a fertile ground for pathological lying, while in Histrionic-Narcissistic Personality Disorder, characterized by behaviors of dramatization and of acceptance or attention seeking, lies are used in terms of self confirmation and become often obvious to other people.[4] Finally, as far as the connection between pseudologia fantastica and delusion is

concerned, the boundaries can be blurred, imposing a differential diagnosis approach seeking a possible psychotic disorder or atypical affective disorder.

Emil Kraepelin, on the outskirts of the dementia praecox, had reported cases of patients with unremitting fantastic stories, without illusions which called parafrenia fantastica.[20] Indeed, despite the contradictions or exaggerations of the pathological liar, pathological lying may be considered as delusional. Nevertheless, unlike the delusional patient, when clear evidence contradicting the content of lying is presented, the pathological liar may acknowledge, at least in part, his mendacious narration or more frequently alter it. Notably, pseudologia fantastica always has some realistic basis unlike the potentially bizarre content of delusions.

The dual/induced pseudology needs frequently a differential diagnosis argumentation from shared psychosis (folie à deux). There is a primary and a secondary pseudologue. Every lie believable by more than one persons cannot be classified as shared pseudology (especially when the primary pseudologue has dominant personality and persuasion, the lie seems plausible and the secondary pseudologue is characterized by naiveté and passivity) as in cases of "collaboration in lying", where there are external incentives or benefits (e.g. manipulative behavior, deception or false testimony in court). Pathological lying, serving apparently unconscious psychological needs to both pseudologues via a common path, is distinguished from both, the deliberate and conscious expression of falsehood, as also from shared delusion.[5]

Case description

The clinic case of dual/induced pseudology concerns Lori and Nick:

- Lori is a 38 years old, unemployed mother of two young children, recently divorced with his over 20 years husband. She presented to Community Mental Health Center accompanied by his new partner (Nick) with depressive symptomatology, followed by panic attacks. She was administered with antidepressant and anxiolytic medication with moderate response. No previous history of mental illness, substance or alcohol abuse, physical disease was reported. Family history was unremarkable. Lori grew up in a strict and conservative environment as the only child in a family of three. Her parents were described as successful professionals in their field. Their remarkable age difference was pointed out, inducing unconfirmed suspicions to Lori to be an adopted child. Lori indicated her affective attachment to her father, who was idealized. She had been sleeping in her parents' bedroom until adolescence. As she mentioned, she was not allowed to attend university after graduation from high school by her later-to-be husband. Nevertheless she was married to him despite her parents' objections. Her husband was described as authoritarian, alcoholic, violent, insulting and she was feeling emotionally trapped but also dependent on him. She never worked but managed to fulfill her role as a mother. Her mother died seven years ago. After her father's death, two years ago, Lori faced, as reported, a prolonged grief period. She was socially isolated, introspective, reporting lack of interest, increased appetite with significant weight gain and persistent preoccupation with internet social network sites. Gradually, while her husband's behavior became increasingly violent and insulting, she started telling and narrating stories on a long sexual relationship with an internationally renowned American actor, with whom she recently reconnected, after his suggestion. She was arguing that the famous actor was the biological father of her 12 year old son, whose hair she painted blond in order to "resemble to his biological father". At that time she felt like "a rebel trying to break free from the bondage of marriage" and adopted an eccentric style of exterior appearance. She was claiming that she had often been travelling abroad and also making money as a co-producer in her renowned lover's movies. These stories were ungrounded and without any validity according to her ex-husband and were accessible through social network sites, in which Lori had introduced fake internet profiles and deliberately inaccurate information about herself and her relationship with the renowned actor. Shortly thereafter, she met her present partner, Nick, on internet. Nick was a big fan of the renowned actor, facilitating greatly their getting together. Lori asked for a divorce, left her husband, moved to Athens and went to live with Nick in a very small apartment, while the two children were found in an ambigu-

ous situation between mother and father. The Department of Child and Adolescent Psychiatry of our Community Mental Health Center intervened as the children had presented with anxiety, depressive symptoms and problems in school.

- Nick is a 22 years old junior military officer. He met Lori on internet (Lori was an internet fellow of his mother) and was accompanying her in all her visits at the Community Center. He maintained a low profile, following obviously obediently and passively Lori's choices. He seemed to manage the relationship with Lori's children more as coeval to them. Nick had been endorsing the narration for Lori's previous relationship with the famous actor, admitting his supposed dominant role in their lives. A jealous type, violent episode of the couple provoked the intervention of the police, alerted by the neighborhood. Nick's parents, strongly opposed to his relationship with Lori, forced Nick to his unintentional admission and hospitalization. A diagnosis of possible psychotic symptomatology was given, which has never been confirmed, neither during a short hospitalization nor in follow-up visits. Nick continues to live with Lori, his parents refuse to meet him, while after the incident and the hospitalization, he was transferred into a low duty position in the army, after a period of follow up by the military mental health services.

Course and clinical outcome

Moderate improvement in Lori's anxiety and depressive symptomatology was notable after modification of the antidepressant and anxiolytic treatment. It should also be taken into account that realistic adverse life events were taking place at that period of time, concerning threats, violent behaviors both on part of her ex-husband for their children's custody and on part of Nick's family for the immediate breaking of their relationship. In this context, Lori's stories about the active role of the famous actor had a clear protective role – according to Lori the famous actor paid weekly visits with his private plane from London, he offered a large amount of money to Nick's family in order to leave them in peace, he used force to her former husband and he supported Lori psychologically in the miscarriage of an alleged pregnancy. Similarly, Nick used to confirm that the famous actor helped Lori and himself by all means to overcome severe difficulties they were facing, although, as he mentioned, he had never met him. Our unit of community psychiatry offered a stable framework of care including Lori's and Nick's individual psychiatric assessment and follow up and also the medical care of the two children from our Child Psychiatry Service.

Differential diagnosis considerations

Besides the diagnosis of mixed Anxiety and Depressive Disorder, Lori's clinical investigation offered abundant narrations, considered as exaggerated, fantastical or unreal. As no evidence of truth was confirmed, the question that arises is whether these stories are delusional or not. It is evident that Lori resorted quite often in these tales in a rather impulsive way, drawing satisfaction by integrating them in her present everyday life and conferring upon them importance. Nick also did so following Lori, to a lesser degree. The content and the affective charge of Lori's stories are not likely to confirm a psychopathological experience of delusional intensity. On the one hand she maintained a good reality control and on the other hand her beliefs had not been unshakeable and did not motivate prejudicial acts. On the contrary, in any attempt by the therapist to challenge or confront some of her excessive narrations or inconsistencies, Lori reacted with discomfort, or came up with excuses (for example that she could not remember details), or she argued that she was tired and she did not like to answer specific questions. Finally, when after one year of follow-up a stronger therapeutic alliance was established, she partially admitted the untruthfulness of her stories, after the therapist' s confrontation. It should also be noted, that in that period of time, Lori had not been receiving any antipsychotic medication systematically (occasionally only quetiapine 100 mg, used as sedative). As we have excluded a delusional context in Lori's beliefs or experiences, then a diagnosis of Delusional Disorder –erotomanic type– or de Clérambault's syndrome has not been retained. Nick, also, was sometimes doubtful about Lori's stories, but kept on confirming her stories. The narrations related to the famous actor did not keep pace with any major mood change of diagnostic importance. Throughout the course of monitoring this case, Lori's mood ranged from mild depressive to normothymic,

while Nick was constantly normothymic. Despite the clear protective role attributed to the imaginary famous partner in a particularly troubled period of Lori's life and the common reference to him in the initial phase of the relationship with Nick, Malingering and Factitious Disorder were excluded as possible diagnosis, as we have not identified a clear external benefit in order to undertake the patient's role. Any disorder due to Substance Abuse or Organic Disease was also excluded. Similarly, intact reality control and cognitive functioning ruled out possible Dissociative Disorder. Finally, a Personality Disorder diagnosis –especially of cluster B– may be strongly supported and discussed, as Lori was characterized by attention seeking, need for admiration, subjective sense of being important, excessive or dramatic emotional expression, minor mood swings, manipulative and dependent behavior. A follow-up of more than sixteen months confirmed this clinical impression, but her ex-husband's unwillingness to cooperate did not permit a reliable evaluation of anterior personality traits.

Moreover, her stories were disproportionally excessive, probably serving more an inner psychological requirement and less a clear need of impressing or handling situations. The MMPI examination was normal and scored high only for falsehood. Nick was constantly following Lori's decisions as, in the past, he followed those of his parents. Clinical observation highlighted on him passivity and dependent personality traits, not confirmed by psychometric tools, due to lack of cooperation, while sporadic monitoring for one year did not reveal any clear or major psychopathological manifestation.

Discussion

We believe that the clinical case described above is a case of shared pseudology. Lori was the primary pseudologue, as after her father's death she had to replace him psychologically with an almighty presence. We assume that her fantasy stories appeared during a grief process, while attempting to escape from the bondage of the past, at a time when daily life conditions seemed intolerable. In this context, her fantasy daydreams on the relationship with the renowned actor acquired a role of true experience, relieving her from reality pressure. Since Lori and Nick got together, they had to balance in a conflictual world, facing fierce criticism, constant pressure for separation, even threats for their lives as well as internal questioning by themselves for their choices and roles towards their family and the community. Under these circumstances, Nick adopted Lori's protective but untrue stories. They both kept on telling lies in a pathological way, without any remarkable evidence of conscious, utilitarian pseudology, on the powerful influence of the famous actor in their lives, meeting their common psychological needs for security, protection and satisfaction.

As far as treatment options are concerned, from the few literature data concerning mainly Factitious Disorder, there is no evidence that confrontation to truth is superior compared to non-confrontation, nor psychotherapy compared to non psychotherapy.[21] In shared psychosis besides pharmaceutical intervention, the separation of induced mentally ill is recommended and usually takes place through hospitalization.[22] Psychotherapy, mainly a systemic approach with mild confrontation techniques in a well established therapeutic relationship, as well as a supportive framework, have been quiet helpful in cases of pseudologia fantastica.[1,23] Our Community Center provided multiple care, both individual and family approach and assured the continuum of care, given that these patients are difficult to engage in a long-term treatment process. This supporting, caring and monitoring context helped gradually Lori in order to set aside her fantasy stories, admit, at least indirectly, the excessiveness and falseness of her narrations and try a realistic re-approach of daily life. A regular follow-up offered by a child psychiatrist and the social worker to the children, the cooperation with the school and the threat of a possible prosecution intervention for neglecting parents, permitted to continue a relatively good schedule of care for the children, with alternation of the primary caregiver's role between Lori and her former husband, while Nick kept a rather passive role.

Conclusion

The phenomenon of shared pseudology is not sufficiently understood both in terms of phenomenological analysis and pathophysiology. Pseudology may be considered as a symptom, as it contends with logical judgment, while the patient moves between reality, fantasy and daydream. It remains an open

question whether it can be a distinct clinical entity and the same can be argued on shared pseudology, which condenses the potential psychopathological severity of pathological lying individually or in group. The manifestation of induced psychopathology has been described by some authors through the term of mental infection, including shared pseudology, shared psychosis and mass hysteria. International literature has reported the role of psychodynamic factors in shared pseudology, while little is known on neurobiological factors involved in it. Community based strategies, offering a spectrum of possibilities of care, may be useful in a further development of the research, both on the most effective therapeutic options and also on the long term evolution of this ambiguous clinical entity.

Δυαδική φανταστική ψευδολογία: Ανασκόπηση και μελέτη κλινικής περίπτωσης

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Ενώ το ψέμα αποτελεί διαχρονικά αναπόσπαστο τμήμα της ανθρώπινης αλληλεπίδρασης, η φανταστική ψευδολογία συνιστά την ψυχοπαθολογική του διάσταση. Υπάρχουν σχετικά ολιγάριθμες αναφορές και αντιφατικές απόψεις όσον αφορά τους ψυχολογικούς μηχανισμούς γύρω από το ψέμα και αμφιλεγόμενα συμπεράσματα για το πότε αυτό αποκτά ψυχοπαθολογική βαρύτητα. Στην παρούσα μελέτη γίνεται βιβλιογραφική ανασκόπηση στην τεκμηρίωση της παθολογικής ψευδολογίας, αλλά και της επακτής/δυαδικής ψυχοπαθολογίας με συγγενή χαρακτηριστικά. Παράλληλα εξετάζεται η δυαδική ψύχωση, η οποία θέτει συχνά διαφοροδιαγνωστικό πρόβλημα, αλλά γίνεται αναφορά και σε φαινόμενα ομαδικής υστερίας. Τα ψυχοπαθολογικά χαρακτηριστικά είναι μάλλον αντιφατικά, όταν εξετάζουμε το παθολογικό ψέμα ως συνειδητή ή μη συνειδητή πράξη. Το DSM IV-TR αναγνωρίζει τη φανταστική ψευδολογία –με τον όρο της «προσποίησης»– και αναφέρεται ως ένα από τα κριτήρια της Ακατανόητα Προσποιητής Διαταραχής (Factitious Disorder). Εξετάζονται τα διαγνωστικά κριτήρια σχετικά με το ψέμα, την εξαπάτηση, την παθολογική ψευδολογία και τις επακτές/δυαδικές τους μορφές. Οι περιπτώσεις δυαδικής ψευδολογίας είναι σπάνιες στη βιβλιογραφία και η κατανόησή τους παρουσιάζει σημαντικά κενά. Παραμένει αμφιλεγόμενο το αν το παθολογικό ψέμα αποτελεί μια αυτόνομη κλινική οντότητα και τονίζεται η ανάγκη για περαιτέρω φαινομενολογική και νευροβιολογική έρευνα. Παρατίθεται κλινική περίπτωση δυαδικής ή επακτής ψευδολογίας, επί ζεύγους χρηστών της μονάδας. Το περιστατικό τεκμηριώνεται κλινικά και βιβλιογραφικά, όπως και η διαφορική του διάγνωση από τη δυαδική ψύχωση, και τίθεται το ερώτημα της συνύπαρξης, σε δεύτερο άξονα, διαταραχής προσωπικότητας, η οποία επίσης τεκμηριώνεται. Περιγράφεται η αντιμετώπιση των δύο ασθενών σε πλαίσιο κοινοτικής ψυχιατρικής, για ένα περίπου έτος, με ατομικές και οικογενειακές παρεμβάσεις, από την υπηρεσία των ενηλίκων και την παιδοψυχιατρική, που αφορούν την ψυχοπαθολογική δυάδα, αλλά και τον πρώην σύζυγο και τα παιδιά της γυναίκας ασθενούς, που παρουσιάζουν σειρά από προβλήματα. Επιτεύχθηκε η ύφεση των ψυχοπαθολογικών φαινομένων, αλλά και η διαχείριση δύσκολων οικογενειακών καταστάσεων που αφορούν τα ανήλικα παιδιά. Η μακροχρόνια παρακολούθηση θα επιτρέψει και την επαλήθευση των διαγνωστικών μας υποθέσεων.

Λέξεις ευρετηρίου: Φανταστική ψευδολογία, επακτή ψευδολογία, δυαδική ψύχωση, ψυχική μόλυνση, διαταραχή προσωπικότητας, κοινοτική ψυχιατρική.

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Special article
Ειδικό άρθρο

Suicide in ancient Greece

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The theme of suicide appears several times in ancient Greek literature. However, each such reference acquires special significance depending on the field from which it originates. Most of the information found in mythology, but the suicide in a mythological tale, although in terms of motivation and mental situation of heroes may be in imitation of similar incidents of real life, in fact is linked with the principles of the ancient Greek religion. In ancient drama and mainly in tragedies suicide conduces to the tragic hypostasis of the heroes and to the evolution of the plot and also is a tool in order to be presented the ideas of poets for the relations of the gods, the relation among gods and men and the relation among the men. In ancient Greek philosophy there were the deniers of suicide, who were more concerned about the impact of suicide on society and also these who accepted it, recognizing the right of the individual to put an end to his life, in order to avoid personal misfortunes. Real suicides will be found mostly from historical sources, but most of them concern leading figures of the ancient world. Closer to the problem of suicide in the everyday life of antiquity are ancient Greek medicines, who studied the phenomenon more general without references to specific incidents. Doctors did not approve in principal the suicide and dealt with it as insane behavior in the development of the mental diseases, of melancholia and mania. They considered that the discrepancy of humors in the organ of logic in the human body will cause malfunction, which will lead to the absurdity and consequently to suicide, either due to excessive concentration of black bile in melancholia or due to yellow bile in mania. They believed that greater risk to commit suicide had women, young people and the elderly. As therapy they used the drugs of their time with the intention to induce calm and repression in the ill person, therefore they mainly used mandragora. In general, we would say that there were many reasons to suicide someone in antiquity. Very important factor was to avoid captivity and the consequent overcrowding of indignity, especially for politicians and military leaders. Also intention in these circumstances was to avoid torture and the disgrace of rape. Strong grief is another reason, as in case of death of family members. The erotic disappointment had place in ancient suicides, which concerned both men and women, while there were also suicide for financial reasons. Especially for the elderly, the despair of the anility in conjunction with physical illness and cachexia, were important factors for these people to decide thee suicidal. Finally, the methods of suicide fitted their epoch, but bear resemblance to those of the modern time. Poisoning was very common to both men and women but equally popular in both sexes was also the hanging. It was not unusual to fall from a high in order to reach the death, while stabbing a sword in the body for self killing was widespread in men and soldiers.

Key words: Suicide, mythology, drama, philosophy, history, melancholia.

Introduction

Ancient Greek literature is rich in references about suicide. All these information derive from various areas of ancient Greek thought and life, such as mythology, drama, philosophy, public life and medicine. Different reasons and different significance can characterize each act of suicide. In this essay we will try to summarize and organize all the material, in order to understand this phenomenon in ancient Greek world.

Suicide in mythology

Due to the fact that ancient Greek society was fully depended by agriculture at least at the early beginning, therefore the fundamental principal of ancient Greek mythology lied on the rural life. That is, the continuous cycle of birth, auto-fertilization, death and so on of the plants, was the basic motive which formed the deeper meaning of ancient Greek myths.[1] In this context the suicide incidents are suitable as a type of death in the representation of the death, which is demanded in ancient Greek mythology, even if each such case is modulate and enriched by anthropomorphic characteristics in the motives and the sentiments of each hero or heroine, who committed suicide in the myths.

Very distinct example is the case of the three daughters of Cecrops, Aglauros, Pandroson and Herse. When Erichthonios was born, Athena put him in a basket and told the three girls not to open it. But due to their curiosity Pandroson and Herse opened it and went mad seeing Erichthonios having the characteristics of a snake, so they jumped of the Athenian Acropilis killing themselves. Reminding their story the Athenians performed the ritual of Arrephoria, where two little girls carried baskets from Acropolis to the shrine of Eros and Aphrodite in its north slope, putting them down in this shrine and took others, carrying them on Acropolis. This ritual symbolized the death and reborn of the earth and the agriculture, where the suicide of the two girls serves as the death and the first phase of the cycle of reborn.[2]

Similar in meaning are the scapegoat rituals performed in many ancient Greek cities, in which a person was in the most cases expelled from the community –only during the ritual and the end returning back– or executed –executions concerned persons, who caused problems in the community such as enemies or criminals convicted to death–, in order to act as a "sponge", which will clean the community of the problems and the misery taking them on their body far from the other citizens. The inner meaning of these rituals is based on the model of the reborn of the earth as it was described above but many explanatory myths which accompanied them, included acts of suicide, in order symbolize the death and justify the expel or the execution of the person during the ritual, which was performed as a reminiscence of the myth. This is the case of the myths of the two daughters of Scedasos, who after being raped by two Spartans suicide due to their disgrace, the myth of the suicide of Sappfo falling from a rock due to the rejection of her love to Phaon by him and the selfless sacrifice of Iphigenia as it is pointed in some versions of her myth, when she is not rescued as the majority of the versions tells. The motive of self-sacrifice for the common good is also found in the female myths of Leontides, Coronides, Hyacinthides, Erechtheidae, who voluntary offered their lives, in order to obey the oracle, which demanded their death, in order their cities to be saved from a plaque or war. Similar male sacrifice is found it the myths of Codrus, the mythical king of Athens, who followed the divination to be killed, in order Athens to win the war. Therefore, he entered the enemy camp, created a disturbance and was killed by the enemies. Same also is the myth of Menoeceus, a descendant of the Spartoi in Thebes, who suicide in order to came true the prediction that Thebes would survive only if one of the Spartoi will be sacrificed.[2]

Nevertheless, putting aside the fact that the principle of the suicide in ancient Greek myths is based on the reborn model, the plot of the myths containing a suicide, are formed in such a way so the characters and the acts of the heros or heroines resemble to the characteristics of the real men and women and therefore their suicide is a result as sometimes the human passions and sentiments can lead to it.

Furor was a great motive for suicide. The must famous mythical suicide, this of Ajax of Salamis, derives from it. Ajax, when he did not received the armor of Achilles, when mad and slaughtered a herd of sheep taking revenge on the Greeks, but when he recovered from his madness, he realized what has he done and suicide as punishment. Analogous is the case of Hercules, who burned himself after the furor, which conquered him realizing that he had

worn a poisoned tunic. We also should remember that cases, where a mythical person is driven mad by a god and suicide. Butes and Lycurgus became mad by Dionysos and committed suicide, while the same fate had Broteas who failed to honor Artemis, therefore the deity let him believe to be immune to fire, finding the death, when he threw himself into it. The gods were frightened by Agdistis's self-castration and caused its son to perform the same self-mutilation and death. In addition, madness is told to be imposed in the myth of Acamas by his female lover, who gave him a box to open in case he decided to never return to her. The box accidentally opened and he went mad finding the death by falling on his sword.[3]

Grief is the most powerful sentiment leading to suicide, which also is an outcome in various instances. The loss of a lover, love without response, abandonment of the lover, loss of the husband and the loss of offspring or other members of the family mark the grief suicides. It is told that Kleitophon, believing that Leukippe is dead or slaughtered by pirates, brought himself in court under false accusations in order to reach the death penalty or jumped into the sea and also Thisbe stabbed herself finding Pyramus dead by suicide. Chaireas was in the steps of suicide, when Kallirhoe did not want to become his. Ameinias suicide, when Narcissus rejected his love, act which forced even Narcissus to suicide, because he could not afford the humiliation he had caused.[3] Suicides in order to avoid grief and the criticism of the society are described in many myths, in which women were abandoned by their lovers, such as the abandonment of Alcinoe by visitor, of Ariadne by Theseus, of Calypso by Odyssey, of Callirhoe by Diomedes, of Dido by Aeneas and of Scylla by Minos.[4] On the other hand, many mythical widows followed their husbands to death committing suicide as are the cases of Alcyone, Cleite, Cleopatra, Deianeira, Evadne, Hylonome, Laeodamea, Marpessa, Oenone, Polydora and Polymede.[4] Numerous references as before are found about women also had suicide in the myths after the death of their children. This is found in the myths of Aethra, mother of Theseus, Ahhaea, mother of Meleager, Antieleia, mother of Odysseus, Arethusa, mother of Corax, Eurydice, when she learned even the death of her last son, Haemon, while she had lost all the other elder children, Niobe, mother of Niobides, Perdix, mother of Talos and Themisto, mother of ten children, who instead of provoking the death of her rival's children, Ino's, she provoked the death of her own children, therefore she committed suicide.[4] In this subcategory we can include the suicide of Aegeus, falling from a rock into the see (the Aegean See), when according to myth he saw the black sails instead of the white one's on the ship of his son, Theseus, as he had instructed him, in case he killed Minotauros, believing that his son was dead. In addition, the loss of other family members provokes the suicide. Erigone, the sister of Orestes suicide after the loss of her brother and Erigone the daughter of Icarus did the same after the loss of her father. Antigone, who lost all her family, is another example, who hanged herself due to similar reasons as above. Also we should not forget the myth of Althaemenes, who accidentally killed his father and prayed with success to be swallowed by the earth.[4]

Shame is another cause, which forced especially women in myths to commit suicide. Shame was found in several occasions, but with more interest in plots with sexual relationships. Many virgins were mentioned to kill themselves after being raped and loosing their virginity. That is the example of the self-hanging of raped Arsippe and the similar self-hanging of raped Nicaea and also the self-hanging of virgins Aspalis and Side, in order to avoid rape. Unique is the myth of Caeneus, who was born as female (Caenis) and asked Poseidon to change sex, after being rapped by him, in order to overcome the shame, but finally as man he could not afford the shame of rape and committed suicide. Shame is also present in the suicide of women who were involved in incestuous relationships, whether as a result of rape or not. That is seen in the myths of Euopis, Halia (raped), Harpallyke, Jocasta, Kanake, Kyane, Niobe, Pelopeia (raped) and Phaedra (raped).[3] The same problem was faced also by men, having in mind the suicides of Cinyras, Clymenus and Valerius, who without knowing had incestuous relationships with their daughters and when they realized it, they killed themselves, while Oidepus is mentioned in different version that after self-blinding, he committed suicide, when he realized his relationship with his mother. From another point of view it is worth to mention the myth of Nycteus, who due to shame have forced her daughter to flee, because she became pregnant by Zeus and then suicide.[4]

Finally, we can complete our presentation of mythical suicides adding some more motives for suicide. Fear is found in the case of Hippodamia, who committed suicide fearing her husband's, Pelops, revenge, after her sons, Thyestes and Atreus, killed their illegitimate half-brother, Chrysippus, to please their mother. Frustration is resent in the mythical suicide of Sirens and Sphinx, after being gained by Odyssey and Oedipus respectively. Two mythical kings, Nisus, king of the Megarians and Agrius, king of the Calydonians committed suicide, when they lost their kingdoms. Anger pushed to suicide Haemon, who did not succeeded to kill his father due to father's bad treatment toward Antigone and also Evenus, who purshed unfortunately his daughter Marpessa and Ida, her's abductor. At the end there is also the case of the forced suicide. This is referred in the myth of Aeson, who was forced to kill himself by Pelias.[10]

Suicide in drama

Close to the suicides in ancient Greek myths stay the suicides described in Greek drama and especially tragedy. Although the poets are inspired by the myths, they use the suicides as a mean in the development of the plot and in a theatrical way. Now the context of suicide should be seen according the ideology of the writer. In the 32 extant tragedies suicides (intentions or committed) exist in 13.[5]

Aeschylus dealt with the conflict among gods.[6] In his plays suicide never happened, except from intentions and threats. Clytemnestra dreamed about it in the Agamemnon, and the Danaids threatened in the Supplices, but this is a poet's mean to attract the pity and the fear of the audience.[5,7]

Sophocles, who promoted the conflict among men and gods, used a lot the suicides.[6] His tragedy, Aiax, is based on this theme and the suicide of the hero is an act of reconciliation with the gods, symbolizing the conflict between the virtues of the previous archaic aristocratic society and these of the new world of the fifth century BC. In the play *Antigone*, where there are three suicides, heroine's suicide expresses the conflict among the unwritten (moral-divine) and written (human) law, while suicides of Haemon and Eurydice in the same play emphasize the tragedy of Antigone and exaggerate the grief for the loss of family persons. Furthermore, Sophocles in the *Trachiniae* presents the suicide of Deianeira, who killed her husband. Her act is not only an act of desperation and guilt, but also a conflict among the well organized under the moral laws society and family, which express the divine harmony and the human passions. About the threats for suicide, we found them expressed by Philoctetes in the homonymous tragedy, signifying the antithesis among the world of the humans and the benevolent divine world. Suicide threats are told by *Elektra* in Sophocles' Elektra, which represent the tragedy of the person, who is desperate after the lost her father and the hypothetical lost of her brother and blaming as human her mother for her misery contra to the moral order.[5–7]

Euripides was interested in representing the human passions and the problems in the interpersonal relationships, therefore he is characterized as the most tragic ancient poet.[6] Phaedra's suicide in the *Hippolytus* is an act for revenge because of her unfulfilled love to her step son, Hippolytus and also an outcome of her shame, when the others knew her inappropriate desire. Menoeceus' suicide in the *Phenissae* reflects the personal sacrifice for the common good as the hero suicide according to the oracle, in order to save his country.[5]

On the other hand, suicide was a subject of jocularity in the New Comedy. We can see it in the fragmenta of Philemon, who put in the mouth of a Euripides' admirer that if it was true, that a dead has eyesight, he would committed suicide to see Euripides.[3]

Suicide in philosophy

Ancient Greek philosophical though was divided in the theme of suicide. As deniers of suicide we can count the Pythagorean philosophers, Plato and Aristotle and as supporters the Stoics and the Epicureans.[8]

Plato in his work *Phaedo* presents Socrates' guarded enthusiasm for the familiar to the Pythagorean dualistic thought opinion, that suicide is always wrongs, while is an act of freeing our souls from the body, which is its jail, where the gods have placed it (Plato *Phaedo* 61b–62c).[9] In his other work, the *Laws*, disapproves suicide as a disgraceful act, believing that those, who committed suicide, should be buried in tombs without signaling. Nevertheless, he will recognize four exceptions, believing that in the following circumstances suicide is an acted of cowardice by persons, who were not able to face

life's changes. That is, when someone's mind is morally corrupted and therefore his character can not be changed, when suicide is a judicial verdict, as in the case of Socrates, when suicide is imposed by great and unavoidable misery and when suicide comes out of shame after unjust acts (Plato *Laws* IX 854a3–5, 873c–d).[10]

Aristotle will express his opinion on the theme in the work *Nicomachean Ethics*. There he condemned suicide as an act of cowardice in front of difficulties and problems, such as poverty, erotic disappointments or other painful event. Even more he will assess suicide as mistake towards the state, without fully justifying this thought (Aristotle *Nicomachean Ethics* 1138a5–14).[11]

On the other hand, the Stoics will justify suicide in five occasions, because in those circumstances man is unable to reach the felicity, which is constituted of virtuous proper to divine perfection. These occasions are, when it is absolute necessity, when there is tyranny, which forces the citizens to act beyond their will breaking the sacred rules, when there is a chronic illness, which does not allow the soul to use its body as a tool for its favor, when there is great hunger and privation and also when there is abnormal drunkenness, which lead to madness.[8]

The Epicureans believed that death is insignificant and the gods did not affect human life. Therefore they did not see suicide as something forbidden and in intolerable situations. But they underlined to their followers that they must not decide easily about the quality of their lives, finding the time to have a second though about suicide.[8]

Antisthenes, the founder of the Cynics, is believed to have expressed the idea to lead oneself out of live and to have written a book to Ajax. Although they did not praised the death, their belief that there is not life after death and their indifference for the body and the material things, did not inhibit them from suicide.[3]

Finally, if we would like to compare the above different philosophical approaches to suicide, we could infer that the deniers are interested more about the effect of the suicide to the society and the defenders more about the effect on the individual.

Suicide in public life

Passing from the intellectual approach to the real incidences of suicide we realize that the information restrict mainly restricted to the historic figures. Trying to describe the situation where these persons were led to the suicide, we will begin with the political and military leaders, who before being captured by the enemies and suffer the tortures and the humiliation, they preferred self-killing.[3]

The most famous is the case of Cleopatra VII, who before being captured by Octavian Augustus probably drunk a mixture of poisons, rather committed suicide by an asp's (egyptian cobra) bite. Diaios, the leader of the last Hellenic coalition against the Romans was defeated by Mummius and before capture committed suicide. General Philoumenos' body, who had organized Hannibal's conquest of Taranto, was never found after Fabius Maximus took back power. It is said that he thrown himself from his horse into a well. Perhaps, General Demosthenes, who participated in the Athenian expedition to Sicily, committed suicide after the defeat, although most sources say that he was captured and found a horrible death after torture. Orator Demosthenes drunk poison before being captured by the forces of Antipater in the island of Kalaureia.[3]

In similar situations analogous fate had also soldiers, women and children. The best illustrated paradigm is this in the monument of Attalus I in Pergamon in memory and in demonstration of his victory over the Gauls-Celts. In the center there was the Gaul, who had just stabbed his wife with his sword and was doing the same to his body. Earlier at the invasion of the Gauls-Celts, three Milesian girl committed suicide in order to avoid being raped by them, as we are informed by an epigram. In 200 BC when Phillip V occupied the city of Abydus, the men stabbed their wives, their children and then themselves. The soldiers of the slave's army in Sicily, which was organized by the slave Eunus, beheaded each other, when their uprising was reaching the defeat. Suicide, falling from the citadel, was again the result of the other slave revolution in Sicily in 104 BC, when they were surrounded.[3]

In times of war except from the voluntary suicide there was also the forced suicide. That is the case of Nikokles, the last king of Pafos, who was obligated to suicide by the soldiers of Ptolemeos. His wife, Axiothea, stabbed their daughters and forced her sisters in law to suicide with her. When Mithridate VI was expelled to the Kingdom of Armenia his second wife, Monime, was forced to suicide as was forced

his palakis, Bereniki too. Olympias, the mother of the Alexander the Great, forced Eurydike to suicide, the wife of the Alexander's half-brother during the struggle for the power after Alexander's death.[3]

Leaving the suicides, which were linked in one or another way to the war and the fear of the human before the captivity, torture and humiliation, we can examine the suicides of various philosophers. A lot of the famous ancient Greek philosophers committed suicide as Pythagoras, Anaxagoras, Speusippos, Diogenes, Epicurus, Zeno the Stoic, Dionysios, Kleanthes, Euphrates and Demonax. It is believed that Empedokles and Aristotle committed suicide too, but this information counts more as an anecdote rather than a true story. All these were at the age of nearly 70 to 80, with the exception of Demonax, who suicide 100 years old. Their suicide has the character of euthanasia, because they took this decision, when they were very old, according the standards of their epoch and most of them suffered from illnesses. Therefore, they wanted to put an end to their lives, in order to avoid suffering, as they had declared in their philosophical teaching.

Staying to the readiness of the elderly to the suicide, we should mention the case of the mother of Darius III, Sisygambris, who lived in respect in the captivity of Alexander the Great. After his death she committed suicide due to the death of her substitute son and her solitude or desperation, as we could say.[3]

In addition, there were some other motives for suicide except the above. Shame led Themestocles' mother to suicide, because she could not stand her son's recourse to the Persian King Artaxerxis, but Themistocles committed suicide (or according to Thucydides died from illness), in order to avoid to go against the interests of the Greeks, participating in the repress of the Egyptian revolution and also to be ungrateful to the Persian King. Shame is also found in homosexual relationships as in the case of Demokles. He refused the love of Demetrios Poliorcetes and did not accept the presents or his threats. He avoided Demetrios Poliorcetes, therefore he did not go to public baths or gymnasiums, but one day he found him in a private bath and jumped into the boiling water. Misery is the motive for suicide of Periandurs' mother, who committed suicide after the fall of her son, because she could not stand her miserable fate. Antigenes, a soldier of Alexander the Great, could not stand his financial problems and committed suicide. Unusual for the Greek world was suicide as manifestation of devotion to the dead master. The only example is that of the two female slaves of Cleopatra VII, Charmion and Iras, probably it happed due to the acceptance of the anatolian customs by Cleopatra VII.[3]

Finally, we should not count for real the stories that an athlete who could not stretch the bow any more jumped into the fire, that Pantites the Spartan arrived later and did not participate in the battle of Thermopylae, therefore he hanged himself returning back to Sparta non standing the disgrace, that one Pythagorean student could not stand the reprehension of his master in front of others and suicide or even the dream interpretation of Artemidorus Daldianus, that people who saw in the dreams that suicide, committed suicide. These stories, even if there is an echo of real events in them (but with many alterations), seem to survive as anecdotes.

Suicide in medicine

Ancient Greek medicines faced the problems of suicides as part of the symptomatology of the two mental illnesses, mania[12] and melancholia[13] and especially the second one. Having as principal that the discrepancy of the four humors (blood, phlegm, yellow and black bile) is the basic problem of all the diseases, they considered that this phenomenon in the organ of logic in the human body will cause its malfunction, which will lead to the absurdity and consequently to suicide, either due to excessive concentration of black bile in melancholia or due to yellow bile in mania.[14] Believing in this idea about the causes and having little interest in the detailed description of the symptoms of the mental ill persons due to their diversity, they preferred to speak about paranoiac behaviors in these two mental illnesses, pointing that melancholia is characterized by fear, where suicide was included.

Few times we will found specific reference to suicide in ancient Greek medical literature. Aristotle will underline that young and elderly are in greater risk of suicide (Aristoteles Phil. et Co. *Problemata* 954b.28–955a.22).[15] Rufus of Ephesus will point that melancholics kill themselves, believing that like this, they will be released from their misery or because they interpret death as pleasant (Aetius Med. *Iatricorum liber vi* 9.65–87).[16] Galen, when he describes the characteristics of the melancholics, he notes that

they are full of fears, accuse their lives for their problems, heat other people, put death in high level and some of them want to suicide (Galenus Med. *De locis affectis libri vi* 8.189.19–8.190.19).[17] Aretaeus of Cappadocia will highlight about melancholics that they face the danger of taking poison and they heat to live (Aretaeus Med. *De causis et signis acutorum morborum* 1.5.3.1–1.5.4.1).[18] Even more he will write that they complain about their lives and want to die (Aretaeus Med. *De causis et signis acutorum morborum* 1.5.5.4–1.5.8.1).[18]. About suicide in mania we will choose only the reference of Aretaius of Cappadocia, because his work comprises all the earlier knowledge about mania and is the only specific example, which links mania and suicide. Describing mania he will note that these patients have peculiar symptomatology, but when their disease is characterized by anger, they are dangerous for others, some of them have killed their servants and also for themselves letting us to think the suicide (Aretaeus Med. *De causis et signis acutorum morborum* 1.6.4.5–1.6.5.3).[18] A special case of suicide is described in the Hippocratic corpus. The author of the work about the diseases of the virgins writes that women suicide more than men and some virgins suicide especially at the time of their period. He believes that responsible for this outcome is the lack of sexual intercourse, which provokes the discrepancy of the humors and especially the discrepancy of blood (Hippocrates Med et Corp. *De virginum morbis* 1.1–45).[19]

Finally, about the therapy these medicines used ancient drugs, which induced calm and repression and also euphoria, in order to change the mood of the patients. Mandragoras was their first choice as we see in the Hippocratic Corpus, where it is recommended for those who want to hang themselves (Hippocrates Med et Corp. *De locis in homine* 39.1–2).[20] But we could infer that they have used all the drugs for mental illnesses such as hellebore, hyosciamus, strychos and dorycnium, since suicide was included in mental disturbance.[14]

Epilogue

We saw the different concepts of suicide in the various fields of ancient Greek thought and life. In order to have a thorough view of the phenomenon, we must add the methods for suicide in ancient Greek world.[3] Poisoning was very common to both men and women but equally popular in both sexes was also the hanging. It was not unusual to fall from a high in order to reach the death, while stabbing a sword in the body for self killing was widespread in men and soldiers. Finally, it is important to remember that a special word for suicide appeared only in the late antiquitym, signifying that with the exception of mental illnesses, suicide was not in the temperament of ancient Greeks and its appearance was more frequent during later times, in which there was great political instability, where the individual could not find security in order to face the personal problems as it was done during the existence of City-State.

Η αυτοκτονία στην αρχαία Ελλάδα

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Το θέμα των αυτοκτονιών εμφανίζεται αρκετά στην αρχαία ελληνική γραμματεία. Όμως, κάθε τέτοια αναφορά αποκτά ειδικό νόημα ανάλογα με το πεδίο από το οποίο προέρχεται. Οι περισσότερες πληροφορίες εντοπίζονται στη μυθολογία, όπου όμως η αυτοκτονία σε μια μυθολογική διήγηση, αν και ως προς τα κίνητρα και την ψυχική κατάσταση των ηρώων μπορεί να ομοιάζει με ανάλογα περιστατικά της αληθινής ζωής, στην πραγματικότητα συνδέεται με τις αρχές της αρχαίας ελληνικής θρησκείας. Στο αρχαίο δράμα και κυρίως στις τραγωδίες, οι αυτοκτονίες συντελούν στην τραγικότητα των ηρώων και στην εξέλιξη της υπόθεσης, γινόμενες ταυτόχρονα εργαλεία

στην παρουσίαση των αντιλήψεων των ποιητών για τις σχέσεων των θεών, των ανθρώπων με τους θεούς και των ανθρώπων μεταξύ τους. Στον χώρο της φιλοσοφίας υπήρξαν οι αρνητές της, οι οποίοι ενδιαφέρονταν περισσότερο για τον αντίκτυπο της αυτοκτονίας στο κοινωνικό σύνολο, όπως και εκείνοι που την αποδέχονταν, οι οποίοι αναγνώριζαν το δικαίωμα στο άτομο να βάλει τέλος στη ζωή του, ώστε να αντιμετωπίσει προσωπικές δυστυχίες. Πραγματικά περιστατικά αυτοκτονιών θα τα πληροφορηθούμε κυρίως από τις ιστορικές πηγές, οι οποίες όμως στην πλειονότητά τους αφορούν σε ηγετικές μορφές του αρχαίου κόσμου. Πιο κοντά στο πρόβλημα των αυτοκτονιών στον καθημερινό βίο της αρχαιότητας βρίσκονται οι απόψεις των αρχαίων Ελλήνων ιατρών, οι οποίες όμως έχουν γενικό χαρακτήρα και δεν επεκτείνονται σε συγκεκριμένα περιστατικά. Οι ιατροί δεν ενέκριναν την αυτοκτονία και την αντιμετώπισαν ως ψυχωσική συμπεριφορά κατά την εξέλιξη των δύο ψυχικών νόσων, της μελαγχολίας και της μανίας, θεωρώντας όμως ότι περισσότερο αφορά στη μελαγχολία. Θεωρούσαν ότι η δυσκρασία των χυμών στο όργανο της λογικής θα προκαλέσει τη μη ορθή λειτουργία του και θα οδηγήσει στον παραλογισμό, εξαιτίας του οποίου θα υπάρξει και το ενδεχόμενο της αυτοκτονίας, πράγμα που θα συνέβαινε, είτε σε υπερβολική συγκέντρωση της μέλαινας χολής στην περίπτωση της μελαγχολίας ή της ξανθής στη μανία. Αναγνώριζαν ότι κινδυνεύουν να αυτοκτονήσουν περισσότερο οι γυναίκες, οι νέοι και οι ηλικιωμένοι. Ως μέσο θεραπείας χρησιμοποιούσαν τα φάρμακα της εποχής τους, όπως έκαναν και στις ψυχικές νόσους γενικότερα, με στόχο να προκαλέσουν ηρεμία και καταστολή στον άρρωστο, άλλα και ευφορία, γι' αυτό κύριο φάρμακο σε αυτές τις περιπτώσεις ήταν ο μανδραγόρας. Γενικότερα, θα λέγαμε ότι ως αιτίες αυτοκτονιών ήταν η αποφυγή της αιχμαλωσίας και του εξευτελισμού, ειδικά για τους πολιτικούς και στρατιωτικούς ηγέτες, όπως και των βασανιστηρίων, αλλά και της ατίμωσης από τους βιασμούς που αυτή θα συνεπάγονταν. Σημαντική αιτία ήταν ακόμη η ισχυρή θλίψη, όπως σε περιπτώσεις θανάτου οικείων προσώπων. Η ερωτική απογοήτευση είχε ακόμη θέση στις αρχαίες αυτοκτονίες, τόσο σε άνδρες, όσο και σε γυναίκες, ενώ ακόμη παρατηρούνταν αυτοκτονίες για οικονομικούς λόγους. Ειδικά για τους ηλικιωμένους, η απόγνωση των γηρατειών σε συνδυασμό με τη σωματική ασθένεια και καχεξία ήταν σημαντικοί παράγοντες που μπορούσαν να ωθήσουν αυτά τα άτομα στην αυτοχειρία. Τέλος, οι μέθοδοι της αυτοκτονίας ήταν ανάλογοι των δυνατοτήτων της εποχής, που όμως έμοιαζαν με τους σύγχρονους. Δηλαδή, η λήψη δηλητηρίου είχε μεγάλη διάδοση, τόσο στους άνδρες, όσο και στις γυναίκες, όπως εξίσου διαδεδομένος ήταν και στα δύο φύλα ο απαγχονισμός. Δεν έλειπαν οι πτώσεις από ύψος, ενώ ο αυτοτραυματισμός με ξίφος αφορούσε περισσότερο στους άνδρες και στους στρατιωτικούς.

Λέξεις ευρετηρίου: Αυτοκτονία, μυθολογία, δράμα, φιλοσοφία, ιστορία, μελαγχολία.

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Special article
Ειδικό άρθρο

Alcohol misuse in Greece: a 15-year experience from a specialized outpatient service*

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Alcohol use in Greece is traditionally diffused among its population. According to general population surveys, three out of four Greeks aged 12–64 referred to alcohol consumption during the last year and 10% reported at least one episode of alcohol abuse during the last month. Furthermore, the large majority of young people aged 13–18 reported lifetime use of alcohol and 14.8% of them reported more than three episodes of alcohol abuse during the last month. Apparently, cultural factors have influenced the pattern of alcohol consumption and the ensuing alcohol-related problems during the last two decades. The "Athena" Service is an outpatient therapeutic unit for the management of substance misusers and their families. It is a specialized abstinence-oriented service that does not administer substance substitutes; mental health professionals of the service work as a multidisciplinary team. Motivational approaches, individual cognitive-behavioural psychotherapy and family interventions of a systemic orientation are the principal therapeutic techniques applied. Adjunctive medication is prescribed whenever mild to moderate concomitant psychopathology is detected. Support measures such as provisional use of medication, use of antagonistic agents or brief hospitalization can be provided if deemed necessary. No strict time limits are applied regarding treatment duration and discharge from the program. During the period 1998–2013, a total of 1511 individuals with alcohol-related problems addressed the service. The changing pattern of substance misuse over the last fifteen years can be summarized as follows: (a) there is a gradually increasing number of women misusing substances; (b) there is an increasing proportion of young adults reporting multi-substance use with concurrent psychiatric disorders; (c) there is an increasing proportion of young adults regularly using/misusing substances; (d) there is a decreasing proportion of middle-aged individuals presenting with chronic alcohol misuse and dependence, with a long-ago onset and slow development of alcohol-related problems; and (e) the proportion of older age individuals presenting chronic alcohol misuse and dependence with con-

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current severe neurological impairments is increasing. Also, detailed information on a sample of 133 individuals who addressed the service for alcohol-related problems during 2012 is given and further discussed. Finally, the need for close monitoring of dangerous alcohol consumption and changing patterns of misuse in times of socio-economic crisis, alongside with an increasing need to provide treatment, is highlighted.

Key words: Alcohol misuse, alcohol dependence treatment, outpatient service, "Athena" service.

Alcohol use in Greece

Alcohol use in Greece is traditionally diffused among its population. Greece is one of the Mediterranean wine-producing countries, and the use of wine has been linked to the socializing and feasting habits of the population since ancient times. Thus, the use of alcohol usually occurs within a social and cultural frame which regulates it. This is considered to be a protective factor regarding alcohol misuse and dependence. In fact, the Greek population presents, on the one hand, a higher percentage of per capita alcohol use compared to other European countries but, on the other hand, a low percentage of heavy alcohol use and misuse.[1] According to general population surveys conducted in the period 1984–2004, a gradual and stable reduction in alcohol consumption in the general population was observed.[2] Despite this, alcohol remains a widely used substance. Thus, three out of four Greeks aged 12–64 referred to alcohol consumption during the last year, 25% of whom consumed alcohol at least ten times during the last month, and 10% reported at least one episode of alcohol misuse during the last month.[2] Also, men use twice as much alcohol than women, and consumption increases with age. Young adults aged 18–25 present the highest percentage of alcohol misuse episodes.[3]

Regarding young people, the large majority of youths aged 13–18 reported lifetime use of alcohol and 14.8% of that sample reported more than three episodes of alcohol misuse during the last month.[4] According to the European School Survey Project on Alcohol and Other Drugs (ESPAD) carried out in 1999, Greece and the UK showed the highest rates of frequent alcohol consumption, where 19% and 17%, respectively, of male students reported drinking alcohol on more than ten occasions in the last 30 days.[4] In general, boys show a higher prevalence of drinking than girls, thus gender differences in alcohol and other drug use are more marked in Greece than in other countries despite the fact that the actual trend is towards more similar behaviour patterns in boys and girls. Apart from cultural patterns explaining this high prevalence, it must be noted that there is no clear age limit on the sale of alcohol to teenagers in Greece. The most recent ESPAD school survey showed a reduction in last month alcohol use among students aged 15–19 during the 25-year period 1984–2011, but a contrasting trend during the last four years.[3]

Another updated source of data on alcohol and other substance use in the school population is available from the "Nationwide Health Behaviour Survey in Adolescents" conducted by the University Mental Health Research Institute (UMHRI) in 2010 in the frame of the international research project "Health Behaviour in School-aged Children" (HBSC, www.hbsc.org). The survey was conducted on a large representative sample of adolescent students (11- to 15-year-olds) from 306 schools.[5] According to the results, one out of three 15-year-old youths consume alcohol at least once a week and one out of four boys drinks three alcohol units per exit, while two out of five have become drunk at least once in their lifetime. This research confirmed a trend of increasing alcohol use and misuse among teenagers, mainly boys, during the last four years.[5]

Family factors, such as living with both parents, parental monitoring of the child, and perceived quality of relationships with parents, seem to play an important role as protecting factors in substance use. Environmental factors strongly associated with substance use include older siblings' and friends' use of legal and illegal substances. Thus, family environment and support, and school attendance are strongly negatively correlated with substance use.[4]

Alcohol misuse and dependence treatment services in Greece

The treatment of alcohol misuse and dependence requires specialized services offering a bio-psychosocial therapeutic approach. Despite the network of prevention and treatment services for substance misuse and addiction that has been widely developing in Greece over the last thirty years, specialized services for alcohol misuse are still few. Three specialized inpatient and four outpatient units are functioning in Athens, one inpatient and one outpatient unit in Thessaloniki, two outpatient services in Crete, in Heraklion and Rethimno, and one in Patras. Most of them operate in state psychiatric hospitals and in general hospitals. Ten more public services are offering counseling and/or treatment to drug addicted individuals, as well as to individuals presenting alcohol-related problems.[3] Non-governmental organizations and self-help groups, such as AA, are operating mostly in the broader Athens Metropolitan area. More recently, several "Clubs of Families with Alcohol-related Problems"[6] have been established in Athens, Patras and Heraklion, functioning as multifamily support groups active at the local level.[7] Furthermore, brief detox programs are available in private hospitals and psychiatric clinics, partly covered by public health insurance.

The "Athena" Service

The "Athena" Service is an outpatient therapeutic unit for the management of substance misuse and dependence and it is part of the 1st Department of Psychiatry of the Athens University Medical School at the Eginition Hospital, operating since 1998 in collaboration with the Greek Organization Against Drugs (OKANA). It is a specialized abstinence-oriented service that does not administer substance substitutes to substance-addicted individuals.[8] Professionals working in the unit are psychiatrists, psychologists and social workers, functioning as a multidisciplinary team. Motivational approaches,[10] individual cognitive-behavioural psychotherapy[10,11] and family interventions of a family system orientation[12–15] are the principal therapeutic techniques applied. Access to the service is free for individuals who present legal and/or illegal substance misuse or dependence, as well as their family members or concerned others. Participation in the program is based exclusively on voluntary consent and is free of charge. The service does not enroll clients with concurrent severe psychopathology (DSM-IV Axis I disorders).[16]

Description of treatment

Alcohol misuse and dependence is a disabling complex disorder of clinical, genetic and neurophysiological heterogeneity, which has extensive comorbidity with other mental disorders.[17] Numerous clinical and epidemiological studies indicate that alcohol related disorders are associated in particular with mood, anxiety, another substance misuse and personality disorders. The occurrence of personality disorders in individuals with drug and alcohol problems has been reported to exceed 70%.[17] The most influential contemporary scientific view about the causes of substance misuse and dependence can best be described by the biopsychosocial model that was first articulated by George Engel[18] in 1977. This model attempts to merge competing addiction theories into an integrated conceptual framework taking into account the complex and diverse interactions between the biological, psychological and social aspects of addiction. The biopsychosocial model recognizes that there are multiple pathways to addiction and that the respective significance of each pathway depends on any single individual, the family, social and cultural environment, and the substance characteristics.[8] Treatment of alcohol use disorders consists of a combination of psychotherapeutic, pharmacological and psychosocial interventions in order to modify the attitudes and the behaviour of the alcohol-dependent individual towards the substance, him/herself and his/her environment.[17]

The "Athena" Service considers psychotherapy as one of the core therapeutic approaches for alcohol-related problems. Research provides strong evidence for the effectiveness of various psychotherapeutic approaches for alcohol use disorders.[19,20] Motivational interviewing, cognitive behavioural therapy, marital and family therapy, and brief interventions are among the main types of therapeutic interventions providing significant benefits for alcohol use disorders,[19] and they are administered at the unit. Adjunctive medication is prescribed whenever

mild to moderate concomitant psychopathology is detected. Given that the program emphasizes on the reduction of substance use and the achievement of abstinence, support measures such as provisional use of medication, use of antagonistic agents or brief hospitalization in a psychiatry department can be provided if deemed necessary.[21] No strict time limits are applied regarding treatment duration and discharge from the program. Thus, end of treatment is set on the basis of mutual agreement between client and therapist, and may therefore vary considerably.[8]

Individual treatment

Motivational interviewing is a well-known approach developed in the 1980s, based on the core principles of Rogerian psychology. Its main focus is on the therapist's behaviour and stance towards the addicted person as critical to its success.[22] The manualized treatment model based on the core techniques of motivational-enhancement therapy has been widely tested in randomized clinical trials with largely positive results.[15] Core to the approach are five basic stances to be adopted by the therapist: (a) expressing empathy about the patient's condition; (b) developing discrepancies regarding the patient's beliefs about his/her behaviour; (c) avoiding arguments about continued substance use; (d) rolling with resistance to change; and (e) supporting patient self-efficacy regarding decisions about behaviour change.[15]

The cognitive-behavioural model considers alcohol misuse and dependence as a disorder of behaviour, beliefs and core beliefs or cognitive schemata, to which the individual is strongly predisposed by underlying personality pathology.[11,23,24] Cognitive-behavioural therapy is applied to minimize excessive emotional reactions and self-destructive behaviours and help modify ways of thinking and the maladaptive beliefs that ensue from these reactions.[8] Therapists attempt to find out which of the client's life problems, such as relationship difficulties, unemployment, health problems, trouble with the law, unstable living arrangements, etc., contribute to the onset and perpetuation of substance misuse, as well as which problems are sequential to substance use. Moreover, situations that make the individual vulnerable to substance use or misuse are identified, techniques for dealing with craving are proposed, social skills are taught, and necessary lifestyle changes are attempted.[23] In general, by choosing feasible objectives and therapeutic directions, the client and the therapist collaborate to modify the dysfunctional behaviour.[8]

Family treatment

The value of including the family as a component of substance misuse treatment has been supported by three main findings: (1) involvement of family members during the pre-treatment phase significantly improves engagement of substance users in treatment; (2) involvement of the family also improves retention in treatment; and (3) long-term outcomes are more positive when families and/or social networks are components of the treatment approach.[15,25,26]

Conjoint family system therapy is used at the "Athena" Service to focus on the entire system of significant others. Couple therapy is used whenever the client is either married or has a stable relationship. The approach is based mainly on the structural-strategic model of treatment developed by Stanton and Todd[12] and on the systemic-motivational therapy developed by Steinglass,[15] and it is usually of short duration, i.e. approximately 12 sessions during a 6 to 9-month period. The principal objectives of therapy are to identify the intrafamilial dynamics and patterns of behaviour that are related to the substance misuse, to reduce high expressed emotion,[27] to ease the feelings of ambivalence towards change within the family, and to facilitate family members to deal with potential crises, relapses, and the resulting difficult situations. Also, dysfunctional communication patterns are made visible and partners are enabled to steer through such situations. Interventions like role-designation, encouraging a substance-free environment at home, close observation of self and others are used to challenge the habitual perseverance in old roles and enhance the likelihood of changing these patterns.[12–15]

Much effort is dedicated to brief family interventions in cases where the substance misusing person is refusing to enter treatment, in order to attain more success in motivating him/her and to increase his/her problem awareness and acceptance of help.

Thus, family members and concerned others are welcome to the Service and are considered as a main target group of therapeutic practice. Effectiveness in reluctant clients entering treatment has been estimated to reach 50% after brief family intervention.

Link to community

The broader social environment plays a major role in individual and family wellbeing, quality of life, attitudes towards substance consumption and efforts to cope with substance related problems. Community reinforcement approaches have been proved to be effective in both substance misuse treatment and relapse prevention. Self-help groups are not widespread in Greece, where a family-oriented culture of support in case of health or other problems is still prevalent. While prevention activities in schools and local communities are widespread and well-organized,[3,28] much has yet to be done towards the implementation of community reinforcement approaches in the field of substance misuse treatment and rehabilitation. As stated above, several AA groups are active in Athens and in some cases a bidirectional referral policy is encouraged within the "Athena" Service. A stronger link has been developing recently with the "Clubs of Families with Alcohol-related Problems",[6] which are operating in Athens, Piraeus, Patras and Heraklion. They are active in communities as multifamily groups oriented to an alcohol-free society and based on mutual support, relapse prevention and enhancement of resilience and healthy resources.[7]

Changes in the profile of individuals addressing the "Athena" Service in the course of the last 15 years

The "Athena" Service has been operating since 1998 on a daily basis. A total sample of 2.983 individuals with substance use, misuse and/or dependence has addressed the unit for help during this 15-year period. Half of them (n=1511, 50.6%) reported alcohol as the main substance of abuse and presented significant alcohol-related problems (table 1). The proportion of alcohol-dependent clients gradually increased over the years due to the fact that the 'Athena' service is one of the few units providing specialized treatment for alcohol-related problems in the broader Athens Metropolitan area. The mean age of clients was 43.8 years; 69.8% of the sample were males (n=1055) and 30.2% were females (n=456). An increase in clients' age-range has been observed during these years (range: 18–76). Furthermore, a gradually increasing number of women have addressed the service. Several other changes have been empirically observed in the profile of clients presenting alcohol-related problems:

Table 1. Profile of individuals who addressed the "Athena" service (1998–2013).

Year	*All substances*	*Alcohol (Men/Women)*
1998	122	36 (28/8)
1999	201	44 (35/9)
2000	226	68 (51/17)
2001	205	71 (56/15)
2002	163	65 (43/22)
2003	156	74 (51/23)
2004	170	83 (5/24)
2005	170	86 (57/29)
2006	179	105 (71/34)
2007	180	114 (89/25)
2008	170	93 (62/31)
2009	185	114 (84/30)
2010	208	129 (93/36)
2011	199	135 (89/46)
2012	198	133 (79/54)
2013	251	161 (108/53)
1998–2013	2983	1511 (50.6%)

- An increasing proportion of young adults (18 to 25 years old) reporting multi-substance use, mainly cannabis and alcohol, presenting concurrent psychiatric or psychological disorders, such as ADHD, depression, eating disorders, aggressive behaviours, various traumatic experiences, i.e. sexual/physical abuse, and personality disorders.
- An increasing proportion of adults (35 to 45 years old), of a relatively high social and professional status, who regularly use or misuse substances, mainly during weekends. Alcohol-use problems had a recent onset and were related to physical or mental health problems, dysfunction in couple/family life, and occupational difficulties (in several cases

unemployment or financial difficulties were linked to the recent Greek economic crisis).

- A decreasing proportion of middle-aged individuals (around 55 years old) presenting with chronic alcohol misuse and dependence, with a long-ago onset and slow development of alcohol-related problems. These people usually suffer from severe and chronic health consequences of alcohol dependence and are more often in need of inpatient treatment. Their alcohol dependence can be linked to socio-cultural circumstances, such as wine production, or to professions highly exposed to alcohol (bars, restaurants, etc.).
- An increasing proportion of older age individuals (over 65 years old) with chronic alcohol misuse and dependence and concurrent severe neurological impairments, chronic severe physical and mental health problems, who usually need long-term inpatient treatment and multi-disciplinary support.

Sociodemographic characteristics of clients addressing the "Athena" Service in 2012

The "Athena" Service participates in the data collection network regarding new clients asking for help in the field of substance misuse and addiction promoted by the Greek Reitox Focal Point. The Pompidou Group Treatment Demand Indicator (TDI)[29] is a questionnaire administered after informed consent to each individual admitted to treatment. The TDI collects basic sociodemographic information, as well as information on patterns of substance use and misuse and previous treatment attempts. Although it has been utilized nationwide in Greece since 2000 by the drug addiction treatment units, its version for clients presenting alcohol misuse has only been adopted since 2010. The Greek Reitox Focal Point is in charge of collecting and elaborating nationwide data yearly, as well as data from every single treatment unit which provides the TDI forms.

During 2012, a total number of 133 individuals presenting alcohol-related problems completed the TDI forms at the "Athena" Service.[30] Almost half of the sample (41.4%) had never asked for treatment anywhere before and only a small percentage had already addressed the unit in the past. The majority (57%) were referred by other services or health professionals. Regarding their sociodemographic characteristics, most were men (58%), with a mean age of 45.4 years (range 20–69), the majority (64%) being within the 30–51 age group (table 2). Forty-four percent were married, 23.3% separated or divorced, and 32.3% were single (table 2). The majority of them (60%) had children. Most of them were Greeks (89.5%) and were residents of the broader Athens Metropolitan area (Attica) (92%). Regarding employment, only a third of them had a stable job (33.6%) and one third were unemployed (34.1%) (table 2). Only 6.8% reported living with another person misusing alcohol or another substance; 40.6% self-reported being middle class, and 49% were of high-school education, whereas 30% had a university degree (table 2).

In terms of pattern of alcohol use, regular alcohol consumption started at a mean age of 33.2 years (range: 15–66) (table 3). At the time of assessment, 39.8% consumed alcohol on a daily basis and 15% reported abstinence during the last month. Mean alcohol consumption during the last month was 8.6 units per day (range: 1–33). The large majority (91.7%) reported no other illegal psychotropic substance use during the last month but 45% reported past use, mainly of cannabis (96.7%), cocaine

Table 2. Socio-demographic characteristics of the clients who addressed the "Athena" service during 2012 (n=133).

		n (%)
Sex	Men	77 (57.9)
	Women	56 (42.1)
Age (years)	30–40 years	35 (26.3)
	41–51 years	50 (37.6)
	52+years	39 (29.3)
Employment	Employed (Fulltime/ Part-time)	43 (32.6)/11 (8.3)
	Unemployed	45 (34.1)
Family status	Married	59 (44.4)
	Single	43 (32.3)
Education	Primary/High-school	13 (9.8)/65 (48.9)
	University degree	31 (23.3)

(73.4%), ecstasy (26.7%), LSD (23.3%) or opiates (73.4%). Types of alcoholic beverages were: wine (31%), beer (26.3%), ouzo and raki (22%), and "hard" drinks, i.e. whisky, vodka, gin etc. (21%). Start mean age of alcohol-related health or behavioural problems was 36.8 years (range: 17–67) (table 3), which corresponds to three years after beginning regular alcohol consumption. Regarding alcohol-related aggressive/violent behaviour, 43% endorsed that they never became verbally of physically violent as a consequence of alcohol consumption, but the rest associated their alcohol use either with verbal aggressiveness (36.8%) or with both verbal and physical violence (20.3%) towards family members (table 3). Frequent drink driving was reported by 28%, whereas 48.6% never drove following alcohol use (table 3). The majority (66.2%) reported having a physical health problem and 46.5% a mental health problem related to their alcohol consumption (table 3); problems with the law related to alcohol misuse were reported by 21%. Regarding the occurrence of alcohol-related problems in the extended family, 47.4% responded affirmatively.

Overall, the profile of clients addressing the "Athena" service compared with the nationwide profile of individuals requesting treatment for alcohol-related problems is as follows: more women, younger people and fewer non-EU citizens addressed the unit, compared with other services.[3] Of importance, approximately one third (n=135; 28.3%) of all clients (n=477) who filled in the TDI nationwide in 2011 entered treatment at the "Athena" Service. These data highlight the increasing importance and the first-line role of the "Athena" service in the Greek network of specialized units offering treatment for alcohol-related problems. The "Athena" Service was evaluated in 2011 by a joint committee of the Greek Ministry of Health and the General Inspector of Public Administration and was found to meet high standards.

Table 3. Pattern of alcohol use and alcohol-related behaviors of the clients who addressed the "Athena" service during 2012 (n=133).

Start mean age of regular alcohol use (mean, range)	33.2 (15–66) years
Start mean age of alcohol-related health or behavioral problems (mean, range)	36.8 (17–67) years
Physical aggressiveness (n, %)	49 (36.8)
Physical/verbal aggressiveness (n, %)	27 (20.34)
Health or behavioral problems (n, %)	71 (53.4)
Drink driving (n, %)	
Never	52 (48.6)
Sometimes	25 (23.4)
Frequently	15 (14.0)

The economic crisis in Greece has deepened since 2010 and the country's economy has shrunk by 20% between 2008 and 2012. Unemployment skyrocketed during this 4-year period (more than tripled) and reached historical peaks.[31] The situation in Greece is exceptionally difficult and the public health sector faces serious and painful cutbacks. State funding for mental health has decreased by more than 20% during these years of austerity, constraining the capacity of mental health services to meet the needs with the 120% increase in use during the past couple of years.[32] The substantial deterioration in mental health is reflected by the considerably increased prevalence of depression and suicidility,[33–36] as well as the increase of illicit drug use with a concomitant sharp rise in the number of new HIV infections.[37] Although a reduction in total alcohol consumption has been reported during the first years of the economic crisis,[38] probably due to the newly imposed high taxes, the longer-term impact of the crisis on alcohol abuse and alcohol-related problems is still unknown. Whatever the case, alcohol treatment services should closely monitor dangerous alcohol consumption and changing patterns of misuse in order to avert a future "epidemic" of alcohol-related problems.

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Κατάχρηση οινοπνευματωδών στην Ελλάδα: 15 χρόνια εμπειρίας στο πλαίσιο ενός εξειδικευμένου εξωτερικού προγράμματος απεξάρτησης

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Η χρήση οινοπνευματωδών αποτελεί διαδεδομένη παραδοσιακή συνήθεια στην Ελλάδα. Σύμφωνα με επιδημιολογικές έρευνες στον γενικό πληθυσμό, τρεις στους τέσσερεις Έλληνες ηλικίας 12–64 ετών ανέφεραν κατανάλωση κάποιου οινοπνευματώδους ποτού κατά τον τελευταίο χρόνο, ενώ το 10% από αυτούς ανέφερε τουλάχιστον ένα επεισόδιο κατάχρησης τον τελευταίο μήνα. Επίσης, η πλειονότητα των εφήβων ηλικίας 13–18 ετών ανέφερε ότι κατανάλωσε κάποιο οινοπνευματώδες ποτό τουλάχιστον μία φορά στη ζωή τους, ενώ το 14,8% από αυτούς ανέφερε τουλάχιστον τρία επεισόδια κατάχρησης τον τελευταίο μήνα. Η διαφοροποίηση στον τρόπο χρήσης οινοπνευματωδών, όπως και οι αλλαγές στα χαρακτηριστικά των ατόμων που παρουσιάζουν προβλήματα σχετιζόμενα με τη χρήση αλκοόλ, συνδέονται με τις πολιτισμικές και οικονομικές αλλαγές στην ελληνική κοινωνία κατά τη διάρκεια των τελευταίων δύο δεκαετιών. Το Πρόγραμμα «ΑΘΗΝΑ» αποτελεί μία εξωτερικού τύπου θεραπευτική μονάδα απεξάρτησης, η οποία απευθύνεται σε άτομα που κάνουν κατάχρηση ή έχουν εξαρτηθεί από παράνομες ψυχοτρόπες ουσίες ή/και αλκοόλ, καθώς και στις οικογένειές τους. Είναι μία εξειδικευμένη «στεγνή» υπηρεσία που δεν χορηγεί υποκατάστατα εθιστικών ουσιών και στελεχώνεται από ειδικούς ψυχικής υγείας που λειτουργούν ως ενιαία διεπιστημονική ομάδα. Στις κύριες θεραπευτικές προσεγγίσεις που εφαρμόζονται στο πρόγραμμα συμπεριλαμβάνονται οι τεχνικές κινητοποίησης, η γνωσιακή-συμπεριφορική ατομική ψυχοθεραπεία και η συστημική ψυχοθεραπεία οικογένειας. Φαρμακευτική αγωγή χορηγείται συνήθως στις περιπτώσεις συννοσηρότητας. Επιπλέον στήριξη προσφέρεται μέσω της χορήγησης φαρμάκων ανταγωνιστών ή/και μέσω βραχείας νοσηλείας σε ειδικό ψυχιατρικό τμήμα, εφόσον αυτό κρίνεται απαραίτητο. Δεν τίθενται αυστηροί χρονικοί περιορισμοί σχετικά με τη διάρκεια και τη λήξη της θεραπείας. Συνολικά, 1511 άτομα με προβλήματα σχετιζόμενα με τη χρήση αλκοόλ απευθύνθηκαν στο Πρόγραμμα «ΑΘΗΝΑ» κατά το διάστημα 1998–2013. Στην παρούσα αποτίμηση περιγράφονται οι σημαντικότερες αλλαγές που παρατηρήθηκαν στα χαρακτηριστικά των ατόμων με προβλήματα σχετιζόμενα με την κατάχρηση αλκοόλ κατά τη διάρκεια της τελευταίας δεκαπενταετίας, όπως: (α) ο σταδιακά αυξανόμενος αριθμός γυναικών που απευθύνονται στο πρόγραμμα, (β) το αυξανόμενο ποσοστό νεαρών ατόμων που παρουσιάζονται με χρήση πολλαπλών ουσιών και συνύπαρξη άλλης ψυχικής διαταραχής, (γ) ο αυξανόμενος αριθμός ενηλίκων με καθημερινή χρήση/κατάχρηση αλκοόλ, (δ) το μειούμενο ποσοστό μεσήλικων ατόμων με χρόνιο πρόβλημα κατάχρησης και εξάρτησης από το αλκοόλ, με έναρξη σε νεαρότερη ηλικία και αργή εξέλιξη των σχετιζόμενων προβλημάτων, και (ε) ο αυξανόμενος αριθμός ηλικιωμένων με χρόνια εξάρτηση από το αλκοόλ και παράλληλες σοβαρές νευρολογικού τύπου επιπλοκές. Επιπλέον, δίνονται στοιχεία σχετικά με τα κοινωνικο-δημογραφικά χαρακτηριστικά των ατόμων με προβλήματα σχετιζόμενα με το αλκοόλ (n=133) που απευθύνθηκαν για βοήθεια στο Πρόγραμμα «ΑΘΗΝΑ» κατά τη διάρκεια του έτους 2012, και επισημαίνεται η ανάγκη επαγρύπνησης των υπηρεσιών απεξάρτησης λόγω των αλλαγών που επέφερε η πρόσφατη οικονομική κρίση.

Λέξεις ευρετηρίου: Κατάχρηση αλκοόλ, απεξάρτηση από το αλκοόλ, εξωτερικό πρόγραμμα απεξάρτησης, Πρόγραμμα «ΑΘΗΝΑ».

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Case report
Ενδιαφέρουσα περίπτωση

Pharmacoresistant partial-onset epilepsy misdiagnosed as panic disorder: A case report

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The clinical differentiation between simple partial epileptic seizures of temporal lobe origin and panic attacks is often difficult on clinical grounds alone, because both conditions are characterized by common symptomatology which includes the feeling of fear, autonomic system dysfunction, disorientation and alternation of the level of consciousness when these conditions evolve clinically. The symptoms stem from common pathophysiologic and anatomic substrates of these two conditions, localized in the limbic system, especially the amygdala. We present the case of a young woman who had a febrile seizure in childhood and subsequent episodes of fear accompanied by tremor and possible alteration of consciousness followed by headache. These spells were diagnosed as panic attacks during her teenage years and she was given Clobazam in order to suppress them. The patient responded well for several years without attacks but her symptoms reappeared following discontinuation of her medication in order to conceive. At that time a detailed history was taken from her spouse and further clinical evaluation raised the suspicion of seizures especially due to the fact that her spells were characterized by alteration of consciousness; she was therefore referred for additional investigations which included admission to a monitoring unit for epilepsy. Long-term video-EEG recording revealed the presence of simple partial seizures with secondary generalization confirming the clinical impression. She was subsequently treated with antiepileptic medications; however the patient's condition worsened to the point where she became pharmacoresistant having failed several antiepileptic drug trials in monotherapy or combination. An MRI scan of the brain revealed the presence of right-sided mesial temporal sclerosis, a known consequence of febrile seizures. Her seizures were nocturnal tonic-clonic and gradually worsened to the point of occurring during most nights. She was therefore referred for a presurgical evaluation which confirmed that the epileptic focus was associated with the area of mesial temporal sclerosis. The epileptic focus was successfully removed from the right anterior temporal lobe and since then she remained free of seizures whereas, in addition, the presumed symptoms of panic

attacks also resolved. This case indicates the occasional difficulty in diagnosing simple partial seizures and how it may be confused with psychiatric conditions. Therefore, the treating physician, especially the psychiatrist, should remain vigilant when treating cases of panic attacks, especially when they present with either atypical symptomatology, such as the case described, or when they do not respond to appropriately chosen treatment; such cases may warrant referral for further investigation.

Key words: Epilepsy, panic attacks, video-EEG, pharmacoresistant.

Introduction

Partial seizures may present with psychiatric symptomatology, often delaying a correct diagnosis and appropriate therapy by several years.[1] On the other hand, the distinction between simple partial seizures and anxiety disorders, especially panic attacks, may be difficult to achieve on clinical grounds alone.[2]

We present the case of a 33 year old right-handed woman who was diagnosed with panic disorder and was so treated for several years prior to establishing that she had partial-onset epilepsy.

Case report

In elementary school she had paroxysmal episodes of fear associated with shivering and flushing sensations lasting 2–3 minutes. There was questionable alteration of consciousness. Initial frequency of the episodes was every several months. These events occurred throughout secondary school and were associated with a post-event headache. At age 19 she had an episode of depression treated successfully with Clomipramine and Clobazam. Since the age of 22 she remained on Clobazam monotherapy for the presumed diagnosis of panic attacks, as described above. Attempts to withdraw Clobazam, in order to conceive, resulted in re-emergence of her symptoms. A brief trial of Lamotrigine for its mood elevating effects was ineffective. Detailed description of the patient's events, by her spouse, revealed the presence of orofacial automatisms and decreased responsiveness which the patient was unaware of.

Her past medical history was remarkable for one episode of febrile convulsions at the age of 2 years. Upon presentation, she was on Clobazam 10 mg bid and denied drug allergies. Family history was significant for a seizure in the patient's paternal grandfather during childhood. Also, a cousin had febrile convulsions. The patient was a civic employee and denied alcohol or tobacco abuse. Physical and neurological examinations were normal except for mild left hand atrophy. Routine electroencephalograms (EEG's) were normal. Brain magnetic resonance imaging (MRI) scan was reported normal.

The patient's family history, the brief duration of her spells, the episode of a febrile seizure, the suggestion of alteration of consciousness, and the suppression of the events by Clobazam, raised the suspicion for simple partial seizures and she was admitted for long-term video-EEG monitoring. During hyperventilation, she reported an event about to occur and, thereafter, she engaged in lip smacking, and became unresponsive for about 3 minutes. Concomitant EEG revealed diffuse slowing with persistent faster frequency activity and sharply contoured components over the right frontotemporal derivations. This activity was of higher amplitude over the right sphenoidal electrode. Interictally rare epileptiform spikes were seen over the right sphenoidal electrode which recorded from the right medial temporal lobe area.

Reinterpretation of her MRI scan revealed subtle right hippocampal asymmetry consistent with mesial temporal sclerosis.

She was subsequently treated with antiepileptic (AED) medications which included Levetiracetam, Lamotrigine, Carbamazepine and Clobazam in various combinations and in monotherapy. Unfortunately she did not respond to treatment and her events became progressively more frequent and intense to the point where she would have nocturnal generalised tonic-clonic seizures.

Readmission to the monitoring unit recorded two seizures consisting of vocalisation followed by oral

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automatisms, tonic posturing and head deviation to the left, progressing to a generalised tonic-clonic seizure. EEG was again associated with a build-up of epileptiform spikes over the right sphenoidal electrode, followed by gradual involvement of all derivations, predominantly the right frontotemporal area.

As the patient became pharmaco-resistant, the possibility of a surgical resection was discussed and she underwent further investigations which included neuropsychological assessment revealing a significant difference between her verbal and performance intelligence at the $p<0.05$ level. Short and long term memory was unimpaired. A Wada test revealed unilateral localization of memory and language functions over the left hemisphere. Repeat MRI scan with improved resolution revealed unequivocal right mesial temporal sclerosis.

At the age of 29 years, she underwent a right anterior hippocampectomy under intraoperative monitoring and resolution of the epileptiform activity on the EEG during surgery. She remained seizure-free thereafter on Lamotrigine monotherapy. Her presumed psychiatric symptoms resolved.

Discussion

This case illustrates the difficulty clinicians often face in distinguishing panic attacks from simple partial seizures.[3] Our patient probably began having simple partial seizures in elementary school and was treated subsequently for presumed depression and panic attacks; the correct diagnosis of partial-onset epilepsy with secondary generalisation was not confirmed until she was 24 years old, about fifteen years after the onset of epilepsy. Such delay has been reported elsewhere as well.[2,4–6]

The case also illustrates the value of a detailed history and physical examination in cases where the presumptive diagnosis fails to respond to appropriately chosen therapies. Suggestive features in our case included the presence of febrile convulsions in childhood, and in family members, a known risk factor for epilepsy.[7] Moreover, subtle asymmetries on physical examination and information provided by the spouse raised the suspicion of epilepsy which led to a re-interpretation of the MRI scan and admission for video-EEG monitoring.

Temporal lobe epilepsy and panic attacks share clinical and probable pathophysiological mechanisms[8] including fear sensation, tachycardia, blood pressure fluctuations and diaphoresis, depersonalization and derealisation, symptoms which may occur both ictally as well as interictally.[5] Anatomically the shared symptomatology stems from the amygdala where limbic symptomatology is expressed and, in addition, electrical stimulation of the area, resembling focal epileptic discharges, commonly elicits panic-like symptoms.[1,4,8–10] Feeling detachment from the environment, and déjà vu phenomena, commonly occur among both groups of patients.[9,11]

The diagnosis of both seizures and panic disorder is often a clinical one based on the constellation of symptoms.[12,13] When a patient presents with atypical symptomatology for either disorder, and fails to respond to adequate treatment, a consideration of an alternative diagnosis is in order.

The reverse situation could also be true as up to 30% of patients considered to have pharmaco-resistant epilepsy turn out to have psychogenic seizures upon further investigations. To complicate matters further, there are patients who exhibit both epileptic as well as non-epileptic seizures.[14] It is therefore critical to consider alternative diagnoses when history and response to treatment do not corroborate.

A normal EEG does not exclude the diagnosis of epilepsy[15] and the best method to assess a patient accurately is by long-term video-EEG monitoring which may clarify the differential diagnosis.[6] Moreover, epileptic seizures may be misdiagnosed if they manifest with psychiatric symptoms,[16] or when seizures occur in patients with no psychiatric illness. In a study of six patients with epilepsy that presented with prominent psychiatric symptoms, and of which only two had pre-existing psychiatric illnesses, three were initially diagnosed with panic attacks, two with psychosis and one with schizophrenia. Of these, five patients had temporal lobe epilepsy, whereas a sixth patient had absence status epilepticus.[16] The value of imaging, especially MRI, is also demonstrated in the above study; patient imaging revealed a dysembryoblastic neuroepithelial tumor in one patient, a cavernous hemangioma in another, post-traumatic changes and bilateral mesial temporal sclerosis in

another, and was normal in two patients with temporal lobe epilepsy. Our case had mesial temporal sclerosis revealed by MRI scanning.

Video-EEG telemetry is therefore instrumental in establishing the diagnosis in difficult cases. This was demonstrated recently in a case of traumatic epidural hematoma following which episodes characterized by anxiety, fear, whole body tingling and associated autonomic symptoms lasting up to two minutes appeared. Consciousness and speech during the spells were preserved prompting the diagnosis of panic attacks.[6] An initial EEG was normal and, even though MRI scan of the brain showed focal encephalomalacia, she was followed for a subsequent period of 8 years without a definite diagnosis until video-EEG was performed and a right temporal epileptic discharge was captured.

Most cases of epilepsy will respond to appropriately chosen AED medication,[17] even though, as in our case, some patients may prove intractable to treatment and require a surgical intervention.[18] The same is true regarding cases with panic attacks. It is therefore imperative for the treating physician, especially the psychiatrist who will most often follow patients with panic attacks and other psychopathology, to remain vigilant regarding the differential diagnosis in cases where the history, clinical description, or response to therapy are atypical. The issue assumes added importance in the case of epilepsy because these patients run the risk of progressing to convulsive seizures and have increased risk for additional morbidity and mortality including sudden unexpected death.[19] On the other hand, prompt recognition and treatment of a seizure disorder will diminish adverse outcomes and enhance quality of life.[20]

Εστιακές φαρμακοανθεκτικές κρίσεις επιληψίας διαγνωσθείσες ως κρίσεις πανικού: Περίπτωση ασθενούς

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Ο κλινικός διαχωρισμός των κρίσεων πανικού από τις απλές εστιακές κρίσεις επιληψίας καθίσταται συχνά δύσκολος καθόσον και οι δύο παθήσεις χαρακτηρίζονται από κοινή συμπτωματολογία η οποία περιλαμβάνει την αίσθηση φόβου, διαταραχές του αυτόνομου νευρικού συστήματος, αποπροσανατολισμό και αλλοίωση του επίπεδου συνείδησης, εφόσον και οι δύο παθήσεις εξελιχθούν κλινικά. Η συμπτωματολογία πηγάζει από κοινό παθοφυσιολογικό και ανατομικό υπόστρωμα για τις δύο παθήσεις, το οποίο εντοπίζεται στο δρεπανοειδές σύστημα, κυρίως στην αμυγδαλή. Παρουσιάζεται περιστατικό γυναίκας η οποία είχε επεισόδιο πυρετικών σπασμών στην παιδική ηλικία και μετέπειτα ανέφερε επεισόδια φόβου συνοδευόμενου από τρόμο και πιθανή αλλοίωση της συνείδησης, τα οποία ακολουθούσε κεφαλαλγία. Τα επεισόδια αυτά διεγνώσθησαν ως κρίσεις πανικού κατά την εφηβική περίοδο και της χορηγήθηκε φαρμακευτική αγωγή με κλοβαζάμη. Η ασθενής απάντησε με πλήρη έλεγχο χωρίς περαιτέρω κρίσεις αλλά τα επεισόδια επανεμφανίστηκαν μετά τη διακοπή της αγωγής με σκοπό να εγκυμονήσει. Κατά την περίοδο αυτή διενεργήθηκε επαναξιολόγηση της κλινικής εικόνας και του ιστορικού κατά την οποία ο σύζυγός της ανέφερε ότι οι κρίσεις χαρακτηρίζονταν από σαφή αλλοίωση της συνείδησης εγείροντας την υποψία επιληπτικών επεισοδίων. Ως εκ τούτου παραπέμφθηκε για πρόσθετη διερεύνηση η οποία περιέλαβε εισαγωγή σε μονάδα καταγραφής κρίσεων. Η παρατεταμένη οπτικο-ηλεκτροεγκεφαλογραφική αξιολόγηση ανέδειξε την παρουσία απλών εστιακών κρίσεων

επιληψίας με δευτεροπαθή γενίκευση επιβεβαιώνοντας την κλινική εντύπωση, και χορηγήθηκαν αντιεπιληπτικά φάρμακα. Παρά τη θεραπεία η επιληψία επιδεινώθηκε και κατέστη φαρμακοανθεκτική, και η ασθενής δεν απαντούσε στα αντιεπιληπτικά φάρμακα που χορηγήθηκαν σε μονοθεραπεία και σε συνδυασμό. Διενεργήθηκε μαγνητική τομογραφία του εγκεφάλου η οποία ανέδειξε την παρουσία μέσης κροταφικής σκλήρυνσης στον δεξιό λοβό, η οποία αποτελεί αναγνωρισμένη επιπλοκή των πυρετικών σπασμών. Οι επιληπτικές κρίσεις εξελίχτηκαν σταδιακά σε τονικοκλονικές και εμφανίζονταν σχεδόν κάθε βράδυ με αποτέλεσμα να προχωρήσει σε περαιτέρω προεγχειρητικό έλεγχο ο οποίος επιβεβαίωσε ότι η επιληπτική εστία εντοπιζόταν στην περιοχή της μέσης κροταφικής σκλήρυνσης. Διενεργήθηκε επομένως αφαίρεση της αναγνωρισθείσας εστίας από τον πρόσθιο κροταφικό λοβό και έκτοτε η ασθενής παρέμεινε ελεύθερη κρίσεων, τα δε θεωρούμενα συμπτώματα πανικού εξέλειπαν. Το περιστατικό αναδεικνύει τη δυσκολία που ενίοτε προκύπτει στη διάγνωση της απλής εστιακής επιληψίας, η οποία χαρακτήριζε την ασθενή, και η οποία χρειάστηκε εξειδικευμένη αξιολόγηση για τελική διάγνωση και θεραπεία, ενώ μπορεί αρχικά να εκληφθεί σαν ψυχιατρική νόσος. Ο θεράπων ιατρός, κυρίως ο ψυχίατρος ο οποίος πρωτίστως χειρίζεται τα περιστατικά αυτά, δέον όπως ευρίσκεται σε εγρήγορση σε περιπτώσεις υποτιθέμενων κρίσεων πανικού που είτε παρουσιάζονται με άτυπη συμπτωματολογία, όπως η περίπτωση που περιγράφεται είτε δεν απαντούν στην ενδεικνυόμενη θεραπεία. Τα περιστατικά αυτά χρήζουν περαιτέρω αξιολόγησης.

Λέξεις ευρετηρίου: Επιληψία, κρίσεις πανικού, βίντεο-ΗΕΓ, φαρμακοανθεκτική επιληψία.

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Books review
Βιβλιοκριτική

Αυτοκαταστροφική συμπεριφορά
Β. Κονταξάκης, Λ. Λύκουρας, Μ. Χαβάκη-Κονταξάκη, Χ. Χριστοδούλου
ΒΗΤΑ Ιατρικές Εκδόσεις, Αθήνα, 2013
ISBN: 978-960-452-166-1

Το πολυσυγγραφικό και εκτεταμένο αυτό βιβλίο των 458 σελίδων έρχεται να καλύψει ένα σημαντικό κενό της Ελληνικής βιβλιογραφίας σε μια εποχή μάλιστα, όπου τα θέματα της ανθρώπινης αυτοκαταστροφικότητας λόγω της οικονομικο-κοινωνικής κρίσης βρίσκονται διαρκώς στην επικαιρότητα.

Η πολυπλοκότητα των φαινομένων της αυτοκαταστροφής αντανακλάται όχι μόνο στην ανάγκη πολυεπίπεδης επιστημονικής θεώρησης αλλά και στις προσπάθειες ερμηνείας και αντιμετώπισής τους από διάφορες σκοπιές. Αυτή ακριβώς την προσέγγιση καλύπτει αυτό το βιβλίο, με μεγάλη μάλιστα επιτυχία, δίνοντας, βέβαια, ιδιαίτερη έμφαση στις βιολογικές-ψυχολογικές και κοινωνικές πλευρές του προβλήματος.

Το ιδιαίτερα καλαίσθητο αυτό βιβλίο χωρίζεται σε επτά μέρη.

Στο πρώτο μέρος καλύπτονται, με τεκμηριωμένο τρόπο, θέματα ορισμών (όπου δυστυχώς επικρατεί μεγάλη σύγχυση σε διεθνές επίπεδο), παρέχονται επιδημιολογικές πληροφορίες για τη διάσταση του προβλήματος, γίνεται μια ιδιαίτερα εκτεταμένη και επιτυχής ιστορική αναδρομή του θέματος και αναπτύσσονται οι παράγοντες κινδύνου αυτοκτονίας, αλλά και οι προστατευτικοί παράγοντες εκδήλωσης αυτοκαταστροφικότητας.

Το δεύτερο μέρος περιλαμβάνει τις σύγχρονες θεωρητικές τάσεις-προσεγγίσεις σε σχέση με τις αυτοκαταστροφικές συμπεριφορές όπως την κλινική-ψυχιατρική, την ψυχοβιολογική, τη γνωσιακή-συμπεριφορική, την ψυχαναλυτική, την υπαρξιακή, την κοινωνιολογική.

Στο τρίτο μέρος αναπτύσσονται τα θέματα της αυτοκτονικότητας σε σχέση με την ψυχική νοσηρότητα. Ιδιαίτερα κεφάλαια αναφέρονται στις διαταραχές της διάθεσης (συναισθηματικές διαταραχές), στις σχιζοφρενικές διαταραχές, στις αγχώδεις διαταραχές, στις διαταραχές προσωπικότητας, στον αλκοολισμό, στην κατάχρηση ουσιών, στις διαταραχές πρόσληψης τροφής.

Το τέταρτο μέρος καλύπτει την αυτοκτονικότητα σε σχέση με τη σωματική νοσηρότητα δίνοντας έμφαση στις νεοπλασματικές παθήσεις, στα καρδιαγγειακά νοσήματα, στα νοσήματα του κεντρικού νευρικού συστήματος, στα ενδοκρινικά νοσήματα και στα νοσήματα του ανοσοποιητικού συστήματος.

Το πέμπτο μέρος αναφέρεται στην αυτοκτονικότητα σε παιδιά, εφήβους και ηλικιωμένους, όπως επίσης και στις διαφορές που εντοπίζονται σε άνδρες και γυναίκες.

Στο έκτο μέρος καλύπτονται σημαντικά ειδικά θέματα όπως η χρησιμότητα των ψυχομετρικών εργαλείων στην αξιολόγηση της αυτοκτονικότητας, οι αυτοκαταστροφικές συμπεριφορές σε περιόδους κρίσης, η σχέση της εποχικότητας με την αυτοκτονικότητα, η επίδραση του διαδικτύου στην αυτοκτονικότητα, η μίμηση αυτοκτονικών συμπεριφορών, ο συνδυασμός ανθρωποκτονίας-αυτοκτονίας, η σχέση των πρώιμων αρνητικών εμπειριών του παιδιού με την κατοπινή αυτοκτονικότητα, η σχέση των τροχαίων ατυχημάτων με τις αυτοκαταστροφικές συμπεριφορές, η σχέση του «ψυχικού πόνου» με την αυτοκτονικότητα και τέλος, οι σύγχρονοι προβληματισμοί γύρω από τα θέματα ευθανασίας και υποβοηθούμενης αυτοκτονίας.

Το έβδομο μέρος του βιβλίου είναι αφιερωμένο στα θέματα πρόληψης και αντιμετώπισης των αυτοκαταστροφικών συμπεριφορών, δίνοντας έμφαση στις ψυχοκοινωνικές και βιολογικές παρεμβάσεις, στη διαχείριση του πένθους μετά την αυτοκτονία, καθώς και στον ρόλο των μέσων μαζικής ενημέρωσης σχετικά με τη σωστή ενημέρωση του κοινού στο πλαίσιο πρόληψης. Το τελευταίο κεφάλαιο αναφέρε-

ται στις προοπτικές της έρευνας στον χώρο της αυτοκαταστροφικής συμπεριφοράς.

Το βιβλίο πιστεύω ότι θα συμβάλει στην προαγωγή της ψυχικής υγείας και θα αποβεί ιδιαίτερα χρήσιμο στους ψυχιάτρους, ψυχολόγους και άλλους επαγγελματίες ψυχικής υγείας, σε όποιον θα ήθελε να έχει έγκυρη ενημέρωση για τα δυσεπίλυτα και πολύπλοκα ψυχοκοινωνικά προβλήματα που συνεπάγονται οι αυτοκαταστροφικές συμπεριφορές.

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Suicidal behaviour
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BETA Medical Editions, Athens, 2013
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This book constitutes interesting and valuable contribution in the Greek literature on the topic of suicidal behaviour. The book is divided in seven parts. The first part deals with definitions, epidemiological data, risk and protective factors. The second, covers theoretical aspects of suicidality including psychiatric morbidity as well as psychobiological, cognitive, psychoanalytic, existential and sociological approaches. The third part discusses in detail issues related to mental disorders and suicidality. The fourth part concerns the relationship between physical illnesses and suicide. The fifth discusses topics related to gender, age and suicide. The sixth part covers special and important topics such as psychometrics of suicidality, financial crises and suicide, seasonality and suicide, internet and suicide, combination of homicide-suicide, traffic accidents and suicide, euthanasia and physician assisted suicide etc. The last part of the book discusses issues related to the prevention of suicidal behaviours on psychosocial and biological level. The book will be very useful for psychiatrists, psychologists and other mental health professionals as well as for every person interested in the field of suicidality.

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Δημόσια Υγεία, Κοινωνική Πρόνοια και Υγειονομική Πολιτική στην Κρητική Πολιτεία (1898–1913)
Ιωάννης Ε. Πολυχρονίδης
Εθνική Σχολή Δημόσιας Υγείας, Εθνικό Ίδρυμα Ερευνών και Μελετών «Ελευθέριος Κ. Βενιζέλος»
Εκδόσεις Παπαζήση, Αθήνα, 2010

Ο Ι. Πολυχρονίδης, νευρολόγος-ψυχίατρος, τερμάτισε τη στρατιωτική του καριέρα ως υποναύαρχος του Υγειονομικού και συνεχίζει, εδώ και πολλά χρόνια, ένα πλούσιο ερευνητικό και συγγραφικό έργο.

Σε αυτόν τον τόμο μάς παρουσιάζει μια εντυπωσιακά εμπεριστατωμένη εικόνα της δημόσιας υγείας, της κοινωνικής πρόνοιας και της υγειονομικής πολιτικής της Κρητικής Πολιτείας (1898–1913).

Δεν διαθέτουμε στην ελληνική βιβλιογραφία πολλά συνθετικά έργα που να επιχειρούν την παρουσίαση των υγειονομικών και προνοιακών υπηρεσιών μιας ολόκληρης γεωγραφικής περιοχής, για μια συγκεκριμένη χρονική περίοδο. Θα αναφέρω τα έργα του πρόωρα χαμένου Ι. Λασκαράτου (Πρόληψη της αρρώστιας και κοινωνική προστασία στα Επτάνησα επί Αγγλοκρατίας 1815–1864, Αθήνα 1985) και του Κ. Σταυρόπουλου (Τα νοσοκομεία και η νοσηλευτική πολιτική της Ελληνικής Εθνότητας στην Κωνσταντινούπολη 1453–1838, Αθήνα 1984).

Η έρευνα του Ι. Πολυχρονίδη δεν περιορίζεται μόνο στα όσα έγιναν στην Κρητική Πολιτεία, αλλά διαθέτει το μεγάλο πλεονέκτημα να τα τοποθετεί στο ιστορικό και κοινωνικό τους πλαίσιο, προτάσσοντας τα κεφάλαια για τη Δημόσια Υγεία στην Ευρώπη, στην Ελλάδα, στην Οθωμανική αυτοκρατορία – η ιστορία της Κρήτης συνδέεται στενά με την τελευταία περίοδο της ύπαρξής της. Τέλος το κεφάλαιο για τις θρησκευτικές πεποιθήσεις, ισλαμικές και χριστιανικές και την επίδρασή τους στις αντιλήψεις για τη δημόσια υγεία και την άσκηση της Ιατρικής.

Αφού τεθεί το πλαίσιο αναφοράς ακολουθούν επτά κεφάλαια όπου παρατίθενται λεπτομερή στοιχεία για τη δημόσια υγεία της Κρήτης, τόσο κατά την Οθωμανική όσο και την περίοδο της Κρητικής Πολιτείας, την υγειονομική νομοθεσία, την υγιεινή των πόλεων, των τροφίμων, των σχολείων και των φυλακών.

Ακολουθούν τα τρία κεφάλαια για τα νοσοκομεία της Κρήτης, τα ελληνικά, το μουσουλμανικό του Ηρακλείου και αυτά των ξένων δυνάμεων. Τα κεφάλαια για το υγειονομικό προσωπικό και την υγειονο-

μική οργάνωση της χωροφυλακής-πολιτοφυλακής, των στρατιωτικών θεραπευτηρίων και νοσοκομείων. Γίνεται εμφανές ότι η ομαλή λειτουργία ενός νοσοκομείου έχει ως όρο τη συνέργεια πολλών, διαφορετικών παραγόντων.

Τα δύο επόμενα κεφάλαια αναφέρονται τόσο στην αντιμετώπιση της λέπρας, τη ριζική περιχαράκωσή της, στη Σπιναλόγκα, όσο και την αντιμετώπιση των ψυχικών νόσων, στο μεταίχμιο μεταξύ της Οθωμανικής περιόδου και της Κρητικής Πολιτείας και μετά την ίδρυση του φρενοκομείου της Νέας Χώρας και του Ασύλου Φρενοβλαβών της Σούδας.

Ακολουθούν τα κεφάλαια για τα υγειονομεία-λοιμοκαθαρτήρια, για την αντιμετώπιση των μεταδοτικών, των αφροδισίων και των άλλων νοσημάτων που απειλούσαν τη δημόσια υγεία, καθώς και την οργάνωση της κτηνιατρικής υπηρεσίας.

Στα κεφάλαια για την κοινωνική πρόνοια που ακολουθούν αποτυπώνονται οι προσπάθειες αλλά και τα προβλήματα της οργάνωσης μιας σταθερής αρωγής για όσους την είχαν ανάγκη, η δυσκολία ολοκλήρωσης των προσπαθειών που ξεκινούσαν με την πρωτοβουλία ιδιωτών, ενώ οι πολεμικές περιπέτειες του Κρητικού πληθυσμού γεννούσαν διαρκείς ανάγκες αρωγής.

Σε οκτακόσιες πενήντα μία σελίδες επιχειρείται ένας εντυπωσιακός περίπλους και αποτυπώνεται το σύνολο των παραμέτρων που ορίζουν τη δημόσια υγεία και την υγειονομική πολιτική της Κρητικής πολιτείας. Μόνο τότε μπορούμε να αποτιμήσουμε ουσιαστικά και ειδικότερα προβλήματα, όπως αυτό της αντιμετώπισης της ψυχικής υγείας και των ψυχικών προβλημάτων του πληθυσμού.

Οι πηγές στις οποίες ανέτρεξε ο συγγραφέας και οι βιβλιογραφικές αναφορές αποτελούν ένα εντυπωσιακό σύνολο. Ο τόμος εμπλουτίζεται από εννέα πίνακες και εβδομήντα τέσσερεις εικόνες. Ανάμεσά τους οι παραγγελίες εγκλεισμού δύο γυναικών «φρενοβλαβών» στην Ιερά Μονή Γονιάς (1899) και ενός άνδρα στο Άσυλο Φρενοβλαβών Σούδας (1911).

Το βιβλίο του Ι. Πολυχρονίδη αποτελεί πλέον την κύρια αναφορά για την υγειονομική ιστορία της Κρητικής Πολιτείας αλλά και υπόδειγμα μεθοδολογίας προσέγγισης της δημόσιας υγείας σε μια γεωγραφική περιοχή και για μια συγκεκριμένη χρονική περίοδο.

Δ.Ν. Πλουμπίδης
Αναπλ. Καθηγητής Ψυχιατρικής
Πανεπιστημίου Αθηνών

Public health, Social welfare and Health Politics in Cretan State (1898–1913)

Ioannis E. Polychronidis
National School of Public Health, National Foundation of Research "Elefterios Venizelos",

Editions Papazisis, Athens, 2010

In this volume of 851 pages are fully documented the public health, social welfare and health politics in Cretan State, in a period of transition between the Ottoman Empire and the union with Greece, from 1898 to 1913. Relevant European, but also Ottoman institutions have influenced the development of an impressive framework of legal measures, public health services and institutions.

An impressive amount of sources and bibliography is cited and also 9 tables and 74 copies of documents permitting to better illustrate the whole process.

D.N. Ploumpidis
Assoc. Professor of Psychiatry
University of Athens

Future scientific meetings
Προσεχείς επιστημονικές εκδηλώσεις

23ο Πανελλήνιο Συνέδριο Ψυχιατρικής
23–26 Απριλίου 2015
Ξενοδοχείο Larissa Imperial, Λάρισα

Στο πλαίσιο του συνεδρίου εντάσσονται και οι παρακάτω επιστημονικές εκδηλώσεις:

- 2ο Πανελλήνιο Ψυχοφαρμακολογικό Συνέδριο
- 1η Πανελλήνια Εκπαιδευτική Ημερίδα Νέων Ψυχιάτρων
- 29η Πανελλήνια Εκπαιδευτική Ημερίδα Ειδικευομένων Ψυχιάτρων

Οργάνωση: Ελληνική Ψυχιατρική Εταιρεία
Επιστημονική Γραμματεία: ΕΨΕ, Παπαδιαμαντοπούλου 11, 115 28 Αθήνα
Τηλ.: (+30) 210-72 14 184, Fax: (+30) 210-72 42 032,
E-mail: psych@psych.gr, Website: www.psych.gr
FB: HELLENIC PSYCHIATRIC ASSOCIATION

- **International Congress of the World Federation, for Mental Health and the Hellenic Psychiatric Association "Living with Schizophrenia", Athens, Greece**
  9–11 October 2014
  Organizers: (a) World Federation for Mental Health, (b) Hellenic Psychiatric Association – Scientific Secretariat: Hellenic Psychiatric Association, 11 Papadiamantopoulou street, GR-115 28 Athens, Greece
  Tel: (+30) 210-72 14 184 – Fax: (+30) 210-72 42 032
  E-mail: psych@psych.gr, Website: www.psych.gr
  Congress Secretariat: ERA Ltd, 17 Asklipiou street, GR-106 80 Athens, Greece – Tel: (+30) 210-36 34 944, Fax: (+30) 210-36 31 690
  E-mail: info@era.gr, Website: www.era.gr

- **2ο Εκπαιδευτικό Σεμινάριο Ψυχονεφρολογίας, Λίμνη Πλαστήρα, Ελλάδα**
  17–18 Οκτωβρίου 2014
  Οργάνωση: Ελληνική Νεφρολογική Εταιρεία
  Επιστημονική Συνεργασία: (α) Μονάδα Ψυχονεφρολογίας Νεφρολογικής Κλινικής, (β) Ιατρικού Τμήματος Πανεπιστημίου Ιωαννίνων, (γ) Εργαστήριο Ιατρικής Ψυχολογίας Ψυχιατρικής Κλινικής, (δ) Ιατρικού Τμήματος Πανεπιστημίου Ιωαννίνων – Οργανωτικό Γραφείο: ΣΥΝΕΔΡΙΑΚΗ ΕΠΕ/ Conferre Ltd, 4ο χλμ Ιωαννίνων –Δωδώνης, 451 10 Ιωάννινα
  Τηλ.: (+30) 2651-068 610, Fax: (+30) 2651-068 611
  E-mail: info@conferre.gr, Website: www.conferre.gr

- **28η Πανελλήνια Εκπαιδευτική Διημερίδα Ειδικευομένων Ψυχιάτρων με θέμα: «Βασικοί άξονες του DSM-5: Προκλήσεις από τα νέα διαγνωστικά κριτήρια», Βόλος, Ελλάδα**
  17–19 Οκτωβρίου 2014
  Οργάνωση: (α) Ελληνική Ψυχιατρική Εταιρεία, (β) Ένωση Ελλήνων Ειδικευομένων Ψυχιάτρων Ελλάδος
  Πληροφορίες: (α) Καθ. Β. Κονταξάκης, (β) Γ. Σαμιωτάκης
  Τηλ.: (+30) 6942 950 257, (+30) 6973 006 545

- **Σεμινάριο με θέμα:» Διάγνωση και Διαχείριση της ΔΕΠΥ σε κάθε ηλικία», Αθήνα, Ελλάδα**
  18–19 Οκτωβρίου 2014 – Υπεύθυνος: Σ. Ζορμπάς
  Τηλ.: (+30) 6946 003 522 – Website: www.adhdhellas.org/

- **World Psychiatric Association Thematic Conference on Intersectional Collaboration, 5th European Congress of the International Neuropsychiatric Association & 2nd Interdisciplinary Congress on Psychiatry and Related Sciences, Athens, Greece**
  30 October–2 November 2014
  Information: Prof C. Soldatos – Website: www.psych-relatedsciences.org

- **2ο Αλληλεπιδραστικό Συμπόσιο στη Συστημική Ψυχοθεραπεία με θέμα «Αναζητώντας το Απρόβλεπτο στην Ψυχοθεραπεία», Ηράκλειο Κρήτης, Ελλάδα**
  1–2 Νοεμβρίου 2014
  Οργάνωση: Εργαστήριο Συστημικής Σκέψης & Εκπαίδευσης
  E-mail: info@ergasystimicis.gr,
  Website: www.unpredictablesymposium2014.com, www.ergasystemicis.gr

- **4th International Forum on Mood and Anxiety Disorder, Vienna, Austria**
  5–7 November 2014
  Organizer: IFMAD 2014
  Congress Secretariat: PUBLI CREATIONS, 74 Boulevard d' Italie, 98000 MONACO – Tel: (+37) 797 97 35 55, Fax (+37) 797 97 35 50
  E-mail: ifmad@publicreations.com, Website: www.publicreations.com

- **1st IAGP International Congress on Research and Group Psychotherapy and Processes on Chronic Sress, Aegly Zappeion, Athens, Greece**
  20–23 November 2014
  Organizer: International Association for Group Psychotherapy and Group Processes (IAGP) – Contact: Dr K. Mela
  Tel: (+30) 6932 470 944, E-mail: catherinemela@gmail.com

- **3ο Συνέδριο της Ελληνικής Εταιρείας Άνοιας "Master Classes in Dementia 2014" Αθήνα, Ελλάδα**
  21–23 Νοεμβρίου 2014
  Οργάνωση: Ελληνική Εταιρεία Άνοιας
  Οργανωτικό γραφείο: ZITA CONGRESS SA – Υπεύθυνη: κ. Μ. Πέτσα
  Τηλ.: (+30) 211-10 01 787, E-mail: m.pe@zita-congress.gr,
  Website: www.3rdcongress-anoiahellas.gr

- **2ο Συνέδριο της Ακαδημίας Δικανικής Ιατρικής & Συναφών Επιστημών, Αθήνα, Ελλάδα**
  21–23 Νοεμβρίου 2014
  Οργάνωση: Ακαδημία Δικανικής Ιατρικής & Συναφών Επιστημών (ΑΔΣΕ) – Οργανωτικό γραφείο: ONE TO ONE Congresses
  Ν. Νικοδήμου 2, 105 57 Αθήνα Τηλ.: (+30) 210-72 54 383-385-386,
  Fax: (+30) 210-72 54 384, E-mail: info@one2onesa.com

- **4ο Πανελλήνιο Συνέδριο Γνωσιακών Ψυχοθεραπειών, Αθήνα, Ελλάδα**
  28–30 Νοεμβρίου 2014 – Οργάνωση: (α) Ιατρικός Σύλλογος Πατρών, (β) Ελληνική Εταιρεία Έρευνας της Συμπεριφοράς
  Επιστημονικοί Συνεργάτες: (α) Α' Ψυχ. Κλ. Πανεπιστημίου Αθηνών, Αιγινήτειο Νοσοκομείο, (β) Β' Ψυχ. Κλ. Πανεπιστημίου Αθηνών – Νοσοκομείο Αττικόν, (γ) Ελληνική Εταιρεία Γνωσιακών Ψυχοθεραπειών, (δ) Ινστιτούτο Έρευνας και θεραπείας της Συμπεριφοράς
  Οργάνωση Συνεδρίου: Easy Travel, Αναγνωστοπούλου 19, 106 73 Αθήνα – Τηλ.: (+30) 210-36 15 201, (+30) 210-36 09 442, Fax: (+30) 210-36 25 572, E-mail: easytravel@hol.gr

- **2ο Πανελλήνιο Συνέδριο Ψυχιατροδικαστικής, Αθήνα, Ελλάδα**
  11–14 Δεκεμβρίου 2014
  Οργάνωση: Ελληνική Ψυχιατροδικαστική Εταιρεία (ΕΨΔΕ)
  Οργανωτικό γραφείο "Global Events", Σταδίου 50Α, 555 35 Πυλαία, Θεσσαλονίκη, Ελλάδα
  Τηλ: (+30) 2310-247 743, (+30) 2310-247 734, Fax: (+30) 2310-247 746
  E-mail: info@globalevents.gr, Website: www.globalevents.gr

- **European Conference on youth mental health: From continuity of psychopathology to continuity of care, Venice, Italy**
  16–18 December 2014
  Organizer: Dr De Girolamo
  Local Organizing Committee: (a) J. Dagani, (b) G. Signorini
  Organizing Secretariat: MCA, Via A. Binda, 34, 201 43 MILAN (Italy)
  Tel: (+39) 02 34934404, Fax: (+39) 02 34934397
  E-mail: info@mcascientificevents.eu,
  Website: www.mcascientificevents.eu, www.youthmentalhealth2014.eu

- **2ο Πανελλήνιο Συνέδριο Ψυχικής Υγείας στην Πρωτοβάθμια Φροντίδα Υγείας, Αθήνα, Ελλάδα**
  18–20 Δεκεμβρίου 2014
  Οργάνωση: Ελληνικό Κολέγιο Γενικών Ιατρών (Ε.ΚΟ.ΓΕΝ.ΙΑ.)
  Επιστημονική Συνεργασία: (α) Παγκόσμια Ψυχιατρική Εταιρεία (WPA), (β) Παγκόσμιος Οργανισμός Υγείας (WHO)
  Τηλ.: (+30) 211-78 09 001, Fax: (+30) 211-78 09 007
  E-mail: info@collegegp.gr, Website: www.collegegp.gr

- **5ο Πανελλήνιο Ψυχιατρικό Συνέδριο στην Πρωτοβάθμια Φροντίδα Υγείας, Ναύπλιο, Ελλάδα**
  22–25 Ιανουαρίου 2015
  Οργάνωση: (α) Ψυχιατρική Κλινική Πανεπιστημίου Πατρών, (β) Ελληνική Νευροψυχιατρική Εταιρεία
  Επιστημονικός συνεργάτης: ΕΛ.Ε.ΓΕ.ΙΑ
  Υπεύθυνος Επικοινωνίας: Καθ. Φ. Γουρζής
  Γραμματεία Συνεδρίου: ERA ΕΠΕ, Ασκληπιού 17, 106 80 Αθήνα
  Τηλ.: (+30) 210-36 34 944, (+30) 210-36 32 950, Fax: (+30) 210-36 31 690
  E-mail: info@era.gr, Website: www.psychprimecare2015.gr

- **1ο Πανελλήνιο Συνέδριο της Ελληνικής Εταιρείας Έρευνας & Πρόληψης των Αυτοκτονιών και της Βίας, Αθήνα, Ελλάδα**
  13–15 Φεβρουαρίου 2015
  Οργάνωση: Ελληνικής Εταιρείας Έρευνας & Πρόληψης των Αυτοκτονιών και της Βίας
  Οργανωτικό Γραφείο: Easy Travel, Αναγνωστοπούλου 19, 106 73 Αθήνα
  Τηλ: (+30) 210-36 15 201/210-36 09 442, Fax: (+30) 210-36 25 572
  E-mail: easytravel@hol.gr

- **5ο Συνέδριο Βιοψυχοκοινωνικής Προσέγγισης στην Ιατρική Περίθαλψη, Θεσσαλονίκη, Ελλάδα**
  19–21 Μαρτίου 2015
  Οργάνωση: Ελληνική Εταιρεία Βιοψυχοκοινωνικής Προσέγγισης στην Υγεία
  Συνεργασία: Γ' Ψυχιατρική Κλινική, Τμήμα Ιατρικής ΑΠΘ
  Οργανωτικό Γραφείο: PRAXICON, Εθν. Αντιστάσεως 101, 551 34 Θεσσ/νίκη
  Τηλ.: (+30) 2310-460 682, Fax: 2310-435 064
  E-mail: info@praxicon.gr, Website: www.praxicon.gr

- **23rd European Congress of Psychiatry, Vienna, Austria**
  28–31 March 2015
  Organizer: European Psychiatric Association (EPA)
  Congress Secretariat: Kenes International, 1-3 Rue de Chantepoulet, P.O. Box 1726 CH-1211, Geneva 1, Switzerland – Tel: (+41) 22 908 0488, Fax: (+41) 22 906 9140, Website: www.epa-congress.org

- **23ο Πανελλήνιο Συνέδριο Ψυχιατρικής, Λάρισα**
  23–26 Απριλίου 2015
  Ξενοδοχείο Larissa Imperial, Λάρισα
  Στο πλαίσιο του συνεδρίου εντάσσονται και οι παρακάτω επιστημονικές εκδηλώσεις: (α) 2ο Πανελλήνιο Ψυχοφαρμακολογικό Συνέδριο, (β) 1η Πανελλήνια Εκπαιδευτική Ημερίδα Νέων Ψυχιάτρων, (γ) 29η Πανελλήνια Εκπαιδευτική Ημερίδα Ειδικευομένων Ψυχιάτρων
  Οργάνωση: Ελληνική Ψυχιατρική Εταιρεία
  Επιστημονική Γραμματεία: ΕΨΕ, Παπαδιαμαντοπούλου 11, 115 28 Αθήνα
  Τηλ.: (+30) 210-72 14 184, Fax: (+30) 210-72 42 032, E-mail: psych@psych.gr, Website: www.psych.gr – FB: HELLENIC PSYCHIATRIC ASSOCIATION

- **International Psychological Applications Conference and Trends, Ljublijana, Slovenia**
  2–4 May 2015
  Organizers: Portuguese Association of Psychoanalysis and Psuchoanalytic Psychotherapy
  E-mail: secretariat@inpact-psychologyconference.org,
  Website: www.inpact-psychologyconference.org

- **4th International Congress on Neurobiology, Psychopharmacology & Treatment Guidance, Agios Nikolaos, Crete, Greece**
  14–17 May 2015
  Organizers: (a) International Society of Neurobiology and Psychopathology, (b) World Psychiatric Association (WPA).
  Under the auspices of: (a) School of Medicine Aristotle University of Thessaloniki, Greece, (b) Hellenic Psychiatric Association (HPA), (c) Psychiatric Association for Eastern Europe and the Balkans (PAEEB)
  Congress Secretariat: Global Events,
  50A Stadiou Street, 555 35 Pilea, Thessaloniki
  Tel: (+30) 2310-247 743, 2310-247 734, Fax: (+30) 2310-247 746
  E-mail: info@globalevents.gr, Website: www.globalevents.gr

- **20th Congress of European Association for Psychotherapy, Athens, Greece**
  19–21 June 2015
  Organizer: European Association for Psychotherapy (EPA)
  Organizing Secretariat: Event Management, Conference & Event Organization 475, Markopoulou street, POB 57, GR-19003 Markopoulo, Attiki – Tel: (+ 30) 22990-84 570, Fax: (+30) 22990-84 572
  Website: http://www.eapathens2015.eu/#!registration/c1jpz

- **Primary Care Mental Health: Innovation and Transdisciplinarity, Bucharest, Romania**
  24–27 June 2015
  Organizers: (a) World Psychiatric Association (WPA), (b) Romanian Association of Psychiatry and Psychotherapy, (c) "Carol Davila" Medical University of Bucharest, (d) Politechnica University Bucharest, (e) National Society of Family Medicine, (f) Romanian Public Health and Health Management Association - Conference Secretariat: Ralcom Exhibitions
  Tel: (+40) 21-210 5814, 21-210 6540, 21-211 1541, Fax: 21-212 2702
  E-mail: registration@wpa2015bucharest.org, abstracts@wpabucharest.org

- **2nd European Congress for Social Psychiatry "Social Psychiatry in the Age of Informatics", Geneva, Switzerland**
  1–3 July 2015
  Organizer: Swiss Society for Social Psychiatry (SSPS-SGSP)
  Co-sponsor: World Association for Social Psychiatry (WASP) Congress Secretariat: Kuoni Congress Geneva
  Tel: (+41) 58 702 6297, E-mail: ecsp2015@ch.kuoni.com,
  Website: www.ecspsocialpsychiatry.org/

- **10th International Congress of the INA, Jerusalem, Israel**
  14–16 October 2015
  Organizing Secretariat: Target Conferences Ltd
  Contact: Sarah, Target Conferences Ltd
  Tel: (011) 972-3-517-5150, E-mail: ina2015@target-conferences.com,
  Website: http://www.ina2015.com/