TÜRKİYE PSİKİYATRİ DERNEĞİ YILLIK TOPLANTISI VE 1. ULUSLARARASI 25. ULUSAL KLİNİK EĞİTİM SEMPOZYUMU

19-22 MAYIS 2022

ALTIN YUNUS OTEL, ÇEŞME

KONUŞMA ÖZETLERİ KİTABI

www.25psikiyatri.org

APPROACH TO THE PATIENT WITH SUICIDAL IDEATION, PLAN AND ACTION

Aytül Karabekiroğlu
Ondokuz Mayıs University Faculty of Medicine, Psychiatry Department

Every year about 800 000 people die due to suicide and there are many more people who attempt suicide. Every suicide is a tragedy that affects families, communities and entire country. Deaths due to suicide has long-lasting effects on the people left behind. Suicide occurs throuhout the life-span and was the fourth leading cause of death among 15-29 years-old globally in 2019 (WHO,2021).

Suicides can be preventable. There are a number of measures that can be taken at population, sub-population and individual levels to prevent suicide and suicidal attempts. Early identification, assesment, management and follow-up anyone who is affected by suicidal behaviour is one of the most effective prevention method among suicide prevention studies.

The management plan is a record of interventions and contingency plans. The management plan should clearly articulate roles, responsibilities and timeframes for the period between assessments. The management plan should also include explicit plans for responding to non-compliance and missed contact by the client. Suicide risk assessment is not static and the management plan should be updated with the most current information available.

The first management decision is treating a person at risk of suicide is to determine the most appropiate and available treatment setting. Management consist of supporting the safety of the person while the underlying mental health problem is treated. Not all persons at risk of suicidal behaviours can or should be hospitilised. Many issues are involved in the decision to hospitilise a person with suicide risk. The decision should be made on clinical grounds with involvement of person and their familiy (Paris,2002).

Assessing the degree of intervention required is dependent on many factors. These are v diagnosis, severity of illness, degree of impulsivity, degree of insight, afety of current situation, whether the person is willing and able to engage with the treating team and other supports, identified protective factors such as supportive family, friends.

Suicide risk management can be especially challenging when clinicians are faced with potentially high-risk situations involving ongoing suicidal and/or self-harm behaviours and urges. Persons diagnosed with personality disorders, particularly borderline or antisocial personality disorders, present a spectrum of suicidal behaviour that ranges from exaggerated threats to actual suicide. There are some principles for management of recurrent or ongoing suicidality such as working as a team, treating comorbid situations careful monitoring the transference and counter-transference (Mehlum, 2001). In this presentation we will discuss the approach to the patient with suicidal ideation, plan and action.

References

Mehlum L (2001) Suicidal behaviour and personality disorder. Current Opinion in Psychiatry, 14(2):131-135;

Paris JC. (2002) Chronic suicidality among patients with borderline personality disorder. Psychiatric Services 53:738-742.

WHO (2021) *https://www.who.int/news-room/fact-sheets/detail/suicide*

REVİEWİNG BY A CASE; CONFRONTİNG SOMEONE ELSE'S SUİCİDE

Prof. Dr. Esra Yancar Demir
Avrasya Üniversitesi, Fen-Edebiyat Fakültesi, Psikoloji AD/Trabzon

İntihar tüm dünyada önemli bir halk sağlığı sorunu olarak görülmektedir. Emile Durkheim ve Maurice Halbwachs önde gelen intihar kuramcılarındandır. Durkheim tarafından intihar etme süreci; "bireyin toplumla olağandan fazla bütünleşmesi sonucu (elcil intihar) ya da yetersiz bütünleşmesi (bencil intihar) neticesinde oluşmakta; bu süreçle birlikte toplumsal düzenin kişi için yetersiz olması (anomik intihar) ya da toplumun aşırı derecede düzen konusunda dikkatli olması (kaderci intihar) da intihara neden olabilmektedir," şeklinde belirtilmiştir İntihar, sonuçları açısından düşünüldüğünde yalnızca intihar davranışını gerçekleştiren kişiyi değil, aynı zaman da yakın çevresinin ruh sağlığını, özellikle de şahitlik etmek durumunda kalınmışsa, çok şiddetli düzeyde etkilemektedir. Yakınları intihar eden kişiler genellikle yoğun üzüntü, suçluluk ve pişmanlık duyguları yaşamakta, hatta travma sonrası stres bozukluğu boyutunda psikopatolojiler geliştirebilmektedirler. Bu kurs kapsamında, yakını ası yoluyla intihar ederken, kendisini arayarak her anını izletmiş EMDR ile tedavi edilen bir olgu üzerinden, yaşanan bu tür büyük travmaların yakınlar üzerinde bıraktığı etkiler s yaşadıkları negatif kendilikle ilgili kognisyonlar ve bunlarla daha sağlıklı baş etme yolları ele alınmaya çalışılmıştır.

Suicide have been accepted as an important public health problem in the whole world. ;Emile Duarkheim and Maurice Halbwachs are the leading theoricians of suicide. According to Durkheim, the process of suicide is defined as "It occurs as a result of the individual's over-integration with society (altruistic suicide) or insufficient integration (egoistic suicide); Along with this process, the inadequacy of the social order for the person (anomic suicide) or the excessive attention of the society about the order (fatalistic suicide) can also cause suicide,

Suicide, when evaluated according to its consequences, does not only effect the person who has commited it, but also strongly effects the mental health of the people close to the person, especially if they had witnessed the process. People who are close to a person who commits suicide usually feel intense sorrow, guilt or regret or even may develop pyshcopathologies such as post traumatic stress disorder. This course covers the effects of big traumas on relatives, their experience on kognitions related to negative self - being and coping with these in a healthy manner through a patient who had to watch a relative commiting suicide by hanging live and is treated by EMDR.

DOES JUSTİCE DEAL WİTH SUİCİDE? LEGAL LİABİLİTY OF THE CLİNİCİAN İN SUİCİDE CASES

Yasin Hasan Balcıoğlu

There are two kinds of psychiatrists: those who have had patients commit suicide and those who will.—Robert I. Simon

Suicidal behavior is one of the few lethal consequences of psychiatric illness. Patient suicide is a tragic and not infrequent event. Because of the possible lethality, it is arguable that the most critical decisions that clinicians face involve assessments of patients' suicidality. Besides the emotional impact on relatives and friends suicide is a stressful event that creates a burden also on the mental health practitioners. The loss of a patient to suicide is the most feared outcome among psychiatrists, while the fear of litigation and liability after such suicide may be a close second. It has been reported that half of the psychiatrists had had a patient who committed suicide. Psychiatrists are expected to possess core competencies in suicide risk assessment and evidence-based psychiatry. However, strikingly, many psychiatrists are never taught how to cope with a suicidal crisis which is also associated with malpractice litigation. For a physician to be found liable to a patient for malpractice, four essential elements must be proved to sustain an assertion of malpractice: duty, negligence, harm, and causation. The incidence of malpractice litigation in the field of psychiatry is increasing. The most common malpractice claim related to psychiatric practice is the failure to provide reasonable protection to patients from committing suicide. The core of a suicide case is whether the psychiatrist properly assessed the patient's suicide risk and whether the suicide was "foreseeable". A failure either to soundly assess a patient's suicide risk or to employ an appropriate safety plan after the suicide potential becomes foreseeable is likely to make a psychiatrist liable if the patient is harmed because of a suicide event. A psychiatrist ought not to be judged negligent because a patient ended his own life, but only because the patient was not carefully assessed or had failed to receive a proper course of treatment. The standard of care in suicide risk assessment does not require the ability to predict suicide, however, the standard of care does require conducting and documenting a thorough suicide risk assessment that facilitates reasonable estimates regarding the level of risk. Obtaining information regarding risk and protective factors is imperative for optimal risk assessment. The suicide risk assessment identifies acute, high-risk suicide

factors and available protective factors that inform the treatment and management of suicidal patients. Clinical experience alone is usually insufficient to support a competent suicide risk assessment. Unaided clinical experience is usually insufficient in conducting suicide risk assessments and in providing expert testimony. Good care combined with good documentation is the surest way to avoid being a defendant in a malpractice action. Indeed, on many occasions, the quality of documentation can determine whether a malpractice attorney accepts or declines a suicide case. Assuming good care, proper documentation of suicide assessments is a clinician's best defense against a potential lawsuit arising from a patient's suicide. Most importantly, proper documentation serves the higher purpose of promoting quality care.

References

1. Ferracuti S, Barchielli B, Napoli C, Fineschi V, Mandarelli G. Evaluation of official procedures for suicide prevention in hospital from a forensic psychiatric and a risk management perspective. Int J Psychiatry Clin Pract. 2020;24:245–9.
2. Packman WL, Pennuto TOC, Bongar B, Orthwein J. Legal issues of professional negligence in suicide cases. Behav Sci Law. 2004;22:697–713.
3. Kaye NS, Soreff SM. The psychiatrist's role, responses, and responsibilities when a patient commits suicide. Am J Psychiatry 1991;148:739–43.
4. Blinder M. Suicide, psychiatric malpractice, and the bell curve. J Am Acad Psychiatry Law. 2004;32:319–23.
5. Simon RI. Suicide risk assessment: Is clinical experience enough? J Am Acad Psychiatry Law. 2006;34:276–8.

COGNİTİVE FORMULATİON AND COGNİTİVE BEHAVİORAL THERAPY İN SUİCİDAL BEHAVİOR

Sedat Batmaz

Department of Psychology, Faculty of Social Sciences and Humanities, Social Sciences University of Ankara, Ankara, Turkey

The conceptual foundations of suicide-specific CBT actually starts from what methods do not work to prevent suicide. As a matter of fact, in this approach, suicidal behavior is considered as a primary problem in itself, rather than a symptom of a mental disorder. CBT is one of the treatment options that a person can receive. Treatment is usually short-term (average of 10 sessions) and focused on the main target. When necessary, treatment can be extended to a continuation phase where other clinically viable problem areas can be addressed.

The suicide-specific cognitive model is integrative and is based on the interaction of the psychological factors that predispose the person to suicide, the cognitive processes associated with mental disorders, and the cognitive processes associated with suicide. In this model, stressful events act as a mediator on predisposing factors and cognitive processes related to both mental disorders and suicide. Among the predisposing psychological factors, research has focused on personality traits such as impulsivity, impulsive aggression, problem solving deficits, low self-efficacy in problem solving, lack of skill in implementing the solutions, tendency to cognitive distortions, perfectionism, excessive general memory style and neuroticism. On the other hand, studies have shown that some beliefs specific to suicide are also common, and it has been found to be especially related to the themes of hopelessness, stress intolerance, loss of sense of belonging, and being a burden to others. Considering all these research results together, it suggests that in the integrative cognitive model of suicide crises, attention processes focus entirely on helplessness and there is no way out of the current situation as a result of selective attention to hopelessness and difficult life events that occur secondary to the situation. This focus leads to the activation of suicide-specific beliefs and the person to develop repetitive suicidal thoughts. If these thoughts are exceeded by a personal threshold, they turn into suicide attempts. Studies have shown that this threshold gradually decreases in people who have attempted suicide before. For this reason, previous attempts become a facilitating factor for recurrent suicide attempts.

When dealing with CBT applications in cases presenting with suicidal behavior, firstly the rationale for this treatment, then both the general model of CBT and the suicide-specific model should be mentioned. CBT for suicide consists of three different stages. It includes obtaining informed consent from the patient in the early phase of treatment, increasing participation in treatment and providing motivation in this direction, detailed assessment of suicide risk, collaborative creation of a safety plan, and case conceptualization. In the middle period of treatment, it is aimed to teach and apply both general CBT strategies and specific CBT strategies for suicide prevention. In the last phase of the treatment, a recurrence prevention protocol is prepared. The issue of the effectiveness of suicide-specific CBT interventions should also be addressed.

It has been shown that CBT approaches developed for suicide provide a significant reduction in recurrence of suicide attempts compared to the usual treatment approaches, and this difference becomes permanent in terms of depression symptoms starting from the sixth month of treatment, but this difference cannot be obtained in the case of hopelessness.

While applying all these treatment approaches, it should be noted that motivational interviewing techniques and non-judgmental awareness can also be used when necessary. In addition, some techniques from other CBT approaches can be applied on issues such as rumination, thinking style and attributions, acting in line with values, and including acceptance as well as change. Thus, the means of struggle in the hands of clinicians and therapists may increase in order to solve a public health problem such as suicide, which may have devastating consequences.

References

1. Bryan, C. J., & Rudd, M. D. (2018). Brief Cognitive-Behavioral Therapy for Suicide Prevention. Guilford Publications.
2. Ellis, T. E., & Newman, C. F. (1996). Choosing to live: How to defeat suicide through cognitive therapy. New Harbinger Publications.
3. Wenzel, A., Brown, G. K., & Beck, A. T. (2009). Cognitive therapy for suicidal patients: Scientific and clinical applications. American Psychological Association.

DIAGNOSIS AND EVALUATION IN DEMENTIA

Erguvan Tugba Ozel- Kizil, M.D., Professor of Psychiatry

Ankara University School of Medicine Department of Psychiatry, Geriatric Psychiatry Unit

Dementia is a neuropsychiatric disorder characterized by progressive deterioration in cognitive functions such as memory, attention, praxis, language, executive , and visuospatial functions. Dementia, which is classified under the title of "Dementia, Delirium, Amnestic and Other Cognitive Disorders" in the DSM-IV classification of the American Psychiatric Association, was included under the title of "Neurocognitive Disorders" and it was renamed as "Major Neurocognitive Disorder" in the DSM-5 (APA, 2013). The nomenclature has changed, since dementia refers to a condition that occurs mostly in elderly individuals and develops due to neurodegenerative disorders while neurocognitive disorder has a broader conceptual framework. For the diagnosis of major neurocognitive disorder, it is necessary to have a significant loss in one or more cognitive areas that is confirmed by the patient himself, his relatives or the clinician, this loss should be documented with standardized neuropsychological tests or clinical evaluation, there should be impaired ability to continue activities of daily living independently due to cognitive losses, and delirium should be excluded. In mild cognitive impairment /minor neurocognitive disorder, there is significant impairment in at least one of the cognitive domains, but this does not prevent the individual from functioning independently. Different diagnostic criteria are recommended for the diagnosis of different etiologies of dementia. Recent studies have indicated that preclinical stages should be taken into account in the diagnosis of Alzheimer's Disease, that not all cases may present with memory impairment, and that certain biomarkers (such as low amyloid level in CSF, amyloid PET imaging)may also be included in the diagnosis. However, these biomarkers are not yet included in clinical diagnostic criteria due to reasons such as they are not stable, inconsistent, and there is no consensus on cut-off values, and they are recommended to be used only for research purposes and to support the diagnosis (McKhann et al. 2011). Both typical (amnestic presentation) and atypical (non-amnestic presentations) Alzheimer's disease were included in the recently recommended diagnostic criteria, and biomarkers were also included in the diagnosis. In this course, it is aimed to provide detailed information about the diagnosis and differential diagnosis of certain dementia etiologies, especially dementia due to Alzheimer's Disease.

References

1. American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders (DSM-5®).American Psychiatric Pub. s. 602-605.
2. McKhann GM Knopman DS, Chertkow H ve ark. (2011). The diagnosis of dementia due to Alzheimer's disease:Recommendations from the National Institute on Aging-Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. Alzheimer's & Dementia, 7: 263-269

ASKERLERDEKİ PSİKİYATRİK SORUNLARIN YÖNETİMİ: OLGULARA NASIL YAKLAŞALIM?

Özgür Maden
SBÜ Sultan 2.Abdülhamid Han Eğitim ve Araştırma Hastanesi, Ruh Sağlığı ve Hastalıkları Kliniği, İstanbul

Askerlik hizmeti diğer ülkelerde olduğu gibi ülkemizde de zorunlu olmakla birlikte askeri personel için bir stresör olmakla birlikte yaşantılarına etki etmektedir. Bu stresörün etkisiyle askerlerde çeşitli ruhsal sorunlar görülebilmektedir. Askeri sağlık sisteminde yapılan düzenlemeler, başta psikiyatri olmak üzere diğer disiplinlerdek, uygulamaların anlaşılmasında bir takım sıkıntılara yol açmaktadır. “Hangi durumda ne yapmalıyız?”, “Hangi tanı ve kararı vermeliyiz? şeklindeki sorular günden güne cevap aramaktadır. Düzenlemiş olduğumuz bu oturumda, askeri personelde sıklıkla görülen olgulara yaklaşım, tedavi algoritmalarının gözden geçirilmesi, uygulamada sıklıkla karşılaşılan durumlar ele alınacaktır.

Bilindiği üzere, askeri sitem hiyerarşik bir sistemdir. Bu sistemde görevli personel, bulunduğu kuvvet, sınıf, rütbe ve kıdeme göre değerlendirilir ve Türk Silahlı Kuvvetleri Sağlık Yeteneği Yönetmeliği (TSK SYY)’ne göre konulan tanı ve verilen kararlara göre işlem görmektedir. Ruhsal bozukluklar bu yönetmeliğin 15, 16, 17 ve 18’nci maddelerinde yer almaktadır. Genel olarak, 15’inci maddede yer alan bozukluklar, psikotik spektrumlu bozukluklar, 16’ncı maddede yer alan bozukluklar nevrotik bozukluklar, 17’nci maddede yer alan bozukluklar, uyum bozuklukları, kişilik bozuklukları, zeka yetersizliği, cinsel kimlik ve davranım bozukluğu ve 18’inci maddede yer alan bozukluklar, organik ruhsal bozukluk, uyku bozuklukları, yaygın gelişimsel bozukluklar, dikkat eksikliği ve hiperaktivite bozukluğu vb. bozukluklardır. TSK SYY’ne göre, hastalıklar dört farklı kategoride ele alınmıştır. A dilimi, “Arızalı-Sağlam” denilen kategoridir. Bu dilim, ruhsal bozuklukların tamamen düzeldiğini ya da tedavi ile kontrol altına alındığını ve işlevselliği etkilemediğini belirtir. B dilimi, “Barışta görev yapamaz, seferde görev yapar./Sınıfı değişikliği” kararının verildiği kategoridir. Başka deyişle, işlevselliği etkileyen, askerlik yapmasına engel olan tekrarlayıcı nitelikteki hastalıkları kategorize eder. C dilimi, ruhsal bozuklukların istirahat veya hava değişimi ya da nekahat dönemlerini ifade eder. D dilimi, “Barışta ve seferde görev yapamaz./Türk Silahlı Kuvvetlerinde görev yapamaz.” Kararını içeren kategoridir. Kronik nitelik kazanmış, işlevselliği tamamen etkileyen, tedavi ile düzelmeyen ruhsal bozukluklar bu kategoride yer alır.

Klinik pratiğindeki uygulamalarda görüldüğü üzere, ruh sağlığı ve hastalıkları uzmanları askeri personele kolaylıkla tanı koyarlarken, raporlarındaki karar verme aşamasında zorluk çekmektedirler. Bu sorunların giderilmesine yönelik, sıklıkla görülen ruhsal bozuklukların neler olduğu, bu bozuklukların sürecinde neler yapılması gerektiği, komplike durumlara nasıl yaklaşılması gerektiği hususlarına dikkat çekerek, akılda kalan soruların açıklığa kavuşturulmasını sağlayarak bu konulardaki belirsizliği gidermeyi hedefledik.

Dünyanın diğer ülkelerinde olduğu gibi ülkemizdeki askeri personelin ruh sağlığına yönelik yaklaşımlar, askerin moral ve motivasyonunun arttırılmasında, zorlu şartlarda görev yapan askeri personele destek olunmasında, askerlik sürecinde yaşanan olumsuz yaşam olaylarına karşı direncin artırılmasında oldukça etkili olmaktadır. Klinisyenlerin ruhsal bozukluklara yaklaşım tarzlarının geliştirilmesi bu etkinin daha verimli olmasını sağlayacaktır.

PSYCHOLOGICAL FIRST AID FOR VIOLENCE AGAINST WOMEN (LIVES)-LISTEN

Dr. Öğr. Üyesi Neşe Yorguner
Marmara University Hospital Department of Psychiatry

Violence against women – particularly intimate partner violence and sexual violence – is a major public health problem and a violation of women's human rights. The most common violence against women in the world is violence perpetrated by a spouse or partner, and one out of every three women is exposed to physical or sexual violence by her close partner at any time in her life (1). Limited studies conducted in our country show similar results. In the "Research on Domestic Violence against Women in Turkey" the prevalence of domestic physical and/or sexual violence was reported as 42% in 2009 and 38% in 2014 (2,3).

Women exposed to violence; may be prone to hide violence due to reasons such as embarrassment, stigma concerns, self-blame, seeing violence as an ordinary case, lack of economic freedom, and fear of further violence. Violence against women is preventable. The health system has an important role to play to provide comprehensive health care to women subjected to violence, and as an entry point for referring women to other support services they may need. Studies have reported that psychiatrists also do not enquire whether women who apply to the psychiatry outpatient clinic have been exposed to violence, and that women do not mention the violence unless the physician asks (4). In addition to limitation of the time allocated to the patient, insufficient experience, and training of health workers on this subject may be important in overlooking the violence (5).

"LIVES", a psychological first aid approach developed by the World Health Organization (WHO), is recommended in primary health care in intimate partner violence (6). Its initials are "LIVES" meaning life, as it aims to protect the lives of women; it includes the steps Listen, Inquire about needs and concerns, Validate, Enhance safety and Support. In this working group, these steps will be examined one by one. Additionally, coping strategies that may be needed in the outpatient clinics and forensic report preparation will be mentioned.

The purpose of the "Listen" step is giving the woman a chance to say what she wants to say in a safe and private place to a caring person who is willing to help. This is important for her emotional recovery. Listening is the most important part of good communication and the basis of first-line support. It involves more than just hearing the woman's words. It means: being aware of the feelings behind her words, hearing both what she says and what she does not say, paying attention to body language – both hers and yours – including facial expressions, eye contact, gestures, sitting or standing at the same level and close enough to the woman to show concern and attention but not so close as to intrude, through empathy, showing understanding of how the woman feels (7).

References

1. Devries KM, Mak JYT, García-Moreno C, Petzold M, Child JC, Falder G, et al. Global health. The global prevalence of intimate partner violence against women. Science. 28 Haziran 2013; 340:1527-8.
2. Türkiye'de kadına yönelik aile içi şiddet araştırması. Ankara: TC Başbakanlık Kadının Statüsü Genel Müdürlüğü; 2009 Ocak.
3. Türkiye'de kadına yönelik aile içi şiddet araştırması. Ankara: TC Aile ve Sosyal Politikalar Bakanlığı Kadının Statüsü Genel Müdürlüğü; 2014 Aralık.
4. Ünal B, Gülseren L. COVID-19 pandemisinin görünmeyen yüzü: Aile içi kadına yönelik şiddet, Klinik Psikiyatri Dergisi 2020; 23 (Ek 1): 89-94
5. Kurt E, Yorguner Küpeli N, Sönmez E, Bulut NS, Akvardar Y. Domestic Violence Among Women Attending to Psychiatric Outpatient Clinic. Arch Neuropsychiatry. 2018; 55:22-8.
6. World Health Organization (2014) Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook. https://www.who.int/reproductivehealth/ publications/violence/vaw-clinical-handbook/en/
7. Yorguner N, Akvardar Y. Kadına Yönelik Şiddet ve Ruh Sağlığı Üzerine Etkisi Kadına Yönelik Şiddetin Anatomisi, Prof. Dr. Gülay Akgül Yılmaz, Editör, Marmara Reklam Pazarlama, İstanbul, ss.139-162, 2018

PSYCHOLOGICAL FIRST AID FOR VIOLENCE AGAINST WOMEN (LIVES APPROACH)- INQUIRE ABOUT NEEDS AND CONCERNS

Erensu Baysak

Psychiatrist, Lüleburgaz State Hospital, Kırklareli, Türkiye

LIVES is a first-line support technique that provides practical care and responds to women's emotional, physical, and safety needs, while ensuring their privacy. First-line support has helped people who have been through various upsetting or stressful events, including women subjected to violence. We should remember this might be our only opportunity to help these women. Women's needs and concerns should be the primary focus during all these steps.

First-line support has 5 steps. The second one involves inquring about needs and concerns.The goal of this step is to learn what is most important for the women. We should respect their wishes and respond to their needs. It is important to remember that when we help them deal with their practical needs (e.g. childcare), it also helps them manage their emotional needs and when we help them with their emotional needs, we strengthen her ability to deal with practical needs.

While listening to women's stories, we should pay particular attention to what they say about their needs and concerns as well as their body language. They may let us know about their physical, emotional, or economic needs, as well as their safety concerns or social support. There are several techniques to help them express what they need and to be sure that we understand them clearly. The questions we ask should be rephrased as invitations to speak, so we should ask open-ended questions. Repeating or restating what the women say help to confirm our understanding. It is important to reflect her feelings and explore the points as needed. We should help them identify and express their needs and concerns. At the end, summarizing the main points that she expressed is suggested.

We do not need to;

Solve all of their problems, convince them to leave a violent relationship, convince them to go to any other services, such as police or the courts, ask detailed questions that force them to reexperience painful events, pressure them to tell us their feelings and reactions to an event. These actions could do more harm than good.

We should avoid several points. We should not ask leading and "why" questions.

References

1. World Health Organization (2014) Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook.
2. Caring for women subjected to violence: a WHO curriculum for training health-care providers. Geneva: World Health Organization; 2019. Licence: CC BY-NC-SA 3.0 IGO.
3. Yorguner N, Akvardar Y. Kadına Yönelik Şiddetin Ruh Sağlığı Üzerine Etkisi. Kadına Yönelik Şiddetin Anatomisi, Prof. Dr. Gülay Akgül Yılmaz, Editör, Marmara Reklam Pazarlama, İstanbul, ss.139-162, 2018.

PSYCHOLOGICAL FIRST AID FOR VIOLENCE AGAINST WOMEN (LIVES APPROACH) - ENSURING SAFETY

Suzan Saner
Free Psychiatrist, İstanbul

World Health Organization and the World Psychiatric Association refer to two guiding principles when working with violence against women; to defend the human rights of women and to promote gender equality. But myths common to mental health professionals may prevent to validate women's statements and helping regulation of feelings. The clinician's ignorance or denial of the symptoms such as fear and anxiety related to violence against women may result in the woman's injury, murder, or suicide attempt.

The Istanbul Convention recommends states to struggle with their own perceptions of honor. Similarly, the LIVES approach suggests healthcare providers to struggle with their own perception of violence against women. It is important for healthcare professionals to understand how their personal values and beliefs affect the service they provide.

Almost half of the women do not tell anyone about sexual harassment. The most common cause is shame and lack of confidence. The first step to validating the survivor's statement is to understand why she remained silent. There are good and valid reasons why survivors choose to remain silent: social and/or psychiatric stigmatization (masochistic, hysterical, borderline women myths) or invisibility, the long-term prolongation of justice and rights-seeking processes, and impunity. Given the low reporting rates, it should not be concluded that there is no need for expert support for survivors.

The feminist principle of "the woman's statement is essential, the burden of proof rests with the man/the suspect" in sexual harassment and rape is an achievement of various resistances and struggles developed by women over time, since their statements are not taken as basis. Insisting that women have the right to define the experience of violence in patriarchal society and to make it a subject's experience forms the basis of survivor-focused recovery. The history of taking the burden of proof off the shoulders of women in sexual crimes inspired the principle of validating the statement in psychological first aid.

The mental, social and economic difficulties of women experiencing violence are not clearly and appropriately included in the DSM diagnostic systems. Most of the women do not see their current or past experiences of violence as their main problem and do not make a connection between sexist violence and their mental illnesses.

The purpose of the "validate" step is to let the woman know that her feelings are normal, that it is safe to express them and that she has a right to live without violence and fear. Validating another's experience means letting the person know that you are listening attentively, that you understand what she is saying, and that you believe what she says without judgment or conditions. In this presentation, the role of validating principle in LIVES approach will be explained in detail. It will be tried to develop validation skills about being aware of and responding to the emotional needs of survivors of male violence.

References

1. Stewart DE, Chandra PS (2017) The World Psychiatric Association (WPA) International Competency-Based Curriculum for Mental Health Care Providers on Intimate Partner Violence and Sexual Violence against Women.
2. WHO (2019) Caring for women subjected to violence: A WHO curriculum for training health-care providers.
3. WHO (2014) Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook.

PSYCHOLOGICAL FIRST AID FOR VIOLENCE AGAINST WOMEN (LIVES APPROACH) - ENSURING SAFETY

Rümeysa Taşdelen
Marmara University Pendik Training and Research Hospital Department of Psychiatry

Violence against women, which is used to express all kinds of acts or threats of acts intended to harm women because of their gender is now well recognised as a public health problem and human rights violation of worldwide significance. The most common violence against women in the world is violence perpetrated by a spouse or partner, and one out of every three women is exposed to physical or sexual violence by her close partner at any time in her life (1). Limited studies conducted in our country show similar results. In the " Research on Domestic Violence against Women in Turkey " the prevalence of domestic physical and/or sexual violence was reported as 42% in 2009 and 38% in 2014 (2,3).

Women exposed to violence; may be prone to hide violence due to reasons such as embarrassment, stigma concerns, self-blame, seeing violence as an ordinary case, lack of economic freedom, and fear of further violence. Studies have reported that psychiatrists also do not enquire whether women who apply to the psychiatry outpatient clinic have been exposed to violence, and that women do not mention the violence unless the physician asks (4). In addition to limitation of the time allocated to the patient, insufficient experience and training of health workers on this subject may be important in overlooking the violence (5)

"LIVES", a psychological first aid approach developed by the World Health Organization (WHO), is recommended in primary health care in intimate partner violence. (6) Its initials are "LIVES" meaning life, as it aims to protect the lives of women; It includes the steps Listen, Inquire about needs and concerns, Validate, Enhance safety and Support . In this working group, these steps will be examined one by one. Additionally, coping strategies that may be needed in the poutpatient clinics and forensic report preparation will be mentioned.

The purpose of the "Enhance safety" step is to assess the woman's circumstances and help her preparing a plan for safety. Some women may not need a safety plan as they do not anticipate recurrence of violence, but it should be discussed that partner violence usually does not stop, may tend to continue, and may worsen or become more frequent over time. Assessing and planning a woman's safety is an ongoing process and more than one session may be required. In interviews, a plan should be prepared together by asking the woman about her personal needs, discussing her options, exploring her resources, and taking into account her changes in condition. (7) In this presentation, the details of the security plan to be prepared with the woman who was subjected to violence will be explained in detail.

References

1. Devries KM, Mak JYT, García-Moreno C, Petzold M, Child JC, Falder G, vd. Global health. The global prevalence of intimate partner violence against women. Science. 28 Haziran 2013;340:1527-8.
2. Türkiye'de kadına yönelik aile içi şiddet araştırması. Ankara: TC Başbakanlık Kadının Statüsü Genel Müdürlüğü; 2009 Ocak.
3. Türkiye'de kadına yönelik aile içi şiddet araştırması. Ankara: TC Aile ve Sosyal Politikalar Bakanlığı Kadının Statüsü Genel Müdürlüğü; 2014 Ara.
4. Ünal B, Gülseren L. COVID-19 pandemisinin görünmeyen yüzü: Aile içi kadına yönelik şiddet Klinik Psikiyatri Dergisi 2020;23(Ek 1): 89-94
5. Kurt E, Yorguner Küpeli N, Sönmez E, Bulut NS, Akvardar Y. Psikiyatri Polikliniğine Başvuran Kadınlarda Aile İçi Şiddet Yaşantısı. Arch Neuropsychiatry. 2018;55:22-8.
6. World Health Organization (2014) Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook. https://www.who.int/reproductivehealth/ publications/violence/vaw-clinical-handbook/en/
7. Yorguner N, Akvardar Y. Kadına Yönelik Şiddet ve Ruh Sağlığı Üzerine Etkisi Kadına Yönelik Şiddetin Anatomisi, Prof. Dr. Gülay Akgül Yılmaz, Editör, Marmara Reklam Pazarlama, İstanbul, ss.139-162, 2018

PSYCHOLOGICAL FIRST AID FOR VIOLENCE AGAINST WOMEN (LIVES APPROACH) -ENSURİNG SAFETY

Emel Kurt
Hisar Intercontinental Hospital, Pychiatry Department, MD

Violence against women, which is used to express all kinds of acts or threats of acts intended to harm women because of their gender is now well recognised as a public health problem and human rights violation of worldwide significance. In the “ Research on Domestic Violence against Women in Turkey “ the prevalence of domestic physical and/or sexual violence was reported as 42% in 2009 and 38% in 2014 (1,2).

In addition to limitation of the time allocated to the patient, insufficient experience and training of health workers on this subject may be important in overlooking the violence (3)

“LIVES”, a psychological first aid approach developed by the World Health Organization (WHO), is recommended in primary health care in intimate partner violence. (4) Its initials are “LIVES” meaning life, as it aims to protect the lives of women; It includes the steps Listen, Inquire about needs and concerns, Validate, Enhance safety and Support . In this working group, these steps will be examined one by one.

The purpose of the “Support” , to connect a woman other resources for her healthy , safety, and social support. Women’s needs generally are beyond what you can provide in the clinic. The clinician can help by discussing the women’s needs with her, telling her about other sources of help, and assisting her to get help if she wants it. The clinician can use some questions about her options. The clinician can discuss to identify about helpline, support groups, crisis ,centre, legal support, mental health consellor, social worker, psychologist. (4)

References

1. Türkiye’de kadına yönelik aile içi şiddet araştırması. Ankara: TC Başbakanlık Kadının Statüsü Genel Müdürlüğü; 2009 Ocak.
2. Türkiye’de kadına yönelik aile içi şiddet araştırması. Ankara: TC Aile ve Sosyal Politikalar Bakanlığı Kadının Statüsü Genel Müdürlüğü; 2014 Ara.
3. Kurt E, Yorguner Küpeli N, Sönmez E, Bulut NS, Akvardar Y. Psikiyatri Polikliniğine Başvuran Kadınlarda Aile İçi Şiddet Yaşantısı. Arch Neuropsychiatry. 2018;55:22-8.
4. World Health Organization (2014) Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook. https://www.who.int/reproductivehealth/ publications/violence/vaw-clinical-handbook/en/

PSYCHOLOGICAL FIRST AID FOR VIOLENCE AGAINST WOMEN (LIVES APPROACH) -ENSURİNG SAFETY

Rengin Güvenç, Psychiatrist
Balıklı Greek Hospital, İstanbul, Türkiye

The vast majority of mental disorders are more common in women. It is associated with a higher incidence of mental illnesses in women with exposure to stress and risk factors rather than a biological predisposition. Clinicians who work with female patients should be trained in working with trauma (1).

As mental health professionals, we encounter the problem of violence against women and the psychological effects of this issue almost every day. One of our main approaches to subjects of violence is to support the person's "empowerment" process. We can take part in different stages of this support process. One of these steps is to provide legal information so that people who are exposed to violence can define the crime and initiate legal action. Recommendations in WHO's "Health care for women subjected to intimate partner violence or sexual violence" handbook include that clinicians should know the laws on partner and sexual violence in their country. It is recommended to know what the laws and policies say for survivors of sexual violence, such as access to abortion services, emergency contraception, access to sexually transmitted diseases prevention methods, and age of sexual consent (2). The empowerment process includes raising awareness by delineating laws and rights related to violence against women, strengthening positive coping ways, discovering and activating social support resources. However, this approach does not include initiating legal processes on behalf of the woman without the consent of the woman. We aim to develop a sense of self-determination and control. According to the law, "the obligation to notify" is given to everyone. As a matter of fact, according to article 7 of the Law, "everyone" can report the situation to the official authorities in case of violence or the risk of violence (3). However, records of someone over the age of 18 should not be shared with third parties and institutions unless officially requested by the judicial authorities. WHO does not recommend mandatory reporting for women. However, it has been emphasized that the persons who come to the forensic examination within a legal application system should be informed before the examination, that the information given during the examination will be reported mandatorily (2).

In this presentation, it will be explained how the reporting will be done in cases where mandatory reporting is required. At the same time, it will be explained how mental examination findings can be used as forensic evidence.

References

1. World Health Organization (2002) Department of mental health and substance dependence. Gend Disparities Ment Health.
2. World Health Organization (2014) Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook. https://www.who.int/reproductivehealth/ publications/violence/vaw-clinical-handbook/en/
3. Gazete R. Ailenin Korunması Ve Kadına Karşı Şiddetin Önlenmesine Dair Kanun. 28239 sayılı Resmi Gazete. 2012.

ADDITIONAL CARE FOR MENTAL HEALTH

Zeynep Beyza Arpacıoğlu
Erenköy Mental Health and Neurological Diseases Training and Research Hospital, Istanbul, Turkey

Intimate partner violence refers to ongoing or past violence and abuse by an intimate partner or ex-partner (a husband, boyfriend or lover, either current or past). Women may suffer several types of violence: physical violence, psychological abuse, controlling behaviours, and sexual violence. Intimate partner violence against women threatens both the mental health and lives of women. World Health Organization recommended first line support (LIVES) approach to women who have been subjected to intimate partner violence. World Health Organization also recommended additional care for mental health to women who have been emotional or mental health problems.

It is important for health care providers to be aware that a woman's health problems may be caused or made worse by violence. Mental health care providers may suspect that a woman has been subjected to violence if she has any of the following; ongoing emotional health issues (such as stress, anxiety or depression), thoughts, plans or acts of suicide, misuse of alcohol or drug.

Many women who are subjected to intimate partner violence will have emotional or mental health problems. These problems will probably get better, most woman recover. But some women will suffer more severely than others. There are specific ways we can offer help and techniques we can teach to reduce women's stress and help them heal. We can provide basic psychosocial support. Basic psychosocial support includes offer LIVES at each meeting, explain that she is likely to feel better with time, help strengthen her positive coping methods, explore the availability of social support, teach and demonstrate stress reduction exercises (such as slow breathing technique and progressive muscle relaxation technique), make regular follow-up appointments for further support.

Patients with mental illness experience high rates of domestic violence, in a systematic review of 42 studies, the median prevalence of adulthood domestic violence among female psychiatric patients was 30%. The most prevalent mental health sequelae of intimate partner violence for female victims are depression, anxiety, posttraumatic stress disorder. In addition to psychiatric treatments, psychoeducation is important in the approach to these situations.

References

1. World Health Organization (2014) Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook.
2. World Health Organization (2019) Caring for women subjected to violence: a WHO curriculum for training health-care providers.
3. Stewart DE, Chandra PS (2017) WPA International Competency-Based Curriculum for Mental Health Providers on Intimate Partner Violence and Sexual Violence Against Women. World psychiatry : official journal of the World Psychiatric Association (WPA), 16(2), 223–224. doi:10.1002/wps.20432

POLİSOMNOGRAFİ KAYIT SİSTEMİ, POLİSOMNOGRAFİDE HASTA HAZIRLAMA VE MONTAJ KURALLARI

Dr. Bülent Devrim Akçay

Polisomnograf (PSG); gece boyunca uykuda birçok fizyolojik parametrenin eş zamanlı kaydı, analiz ve yorumlanmasını belirtmek amacıyla kullanılan bir terimdir. PSG ile insan vücudunun ürettiği elektrik sinyalleri, elektrotlar ve sensörler aracılığıyla kaydedilerek görsel hale getirilir. PSG'de alınan elektriksel sinyaller analog sinyallerdir. Bu sinyaller kaydedilerek dijital veriye çevrilir. Başlangıçta analog sistemde alınan kayıtlar günümüzde yerini digital sistemlere bırakmıştır. PSG cihazları, uyku sırasında nörofizyolojik, respiratuvar, kardiyovasküler gibi fizyolojik parametrelerin genellikle bütün gece boyunca, belli bir periyotla, eş zamanlı ve devamlı kaydedilmesini sağlarlar. PSG'deki teknik ve dijital özellikler, örneklem hızları, istenilen filtre ayarları, teknik ve dijital özellikler uluslararası standardizasyon açısından Uyku ve İlişkili Olayların Puanlanması için AASM Kılavuzu Sürüm 2.6'daki Güncellemeler, 2020 (The AASM Manual for the Scoring of Sleep and Associated Events of Updates, 2020) kılavuzuna göre belirlenir.

PSG'de temel olarak bulunması gereken kanallar: 1.Elektroensefalografi (EEG) derivasyonları (3 derivasyon önerilen F4-M1 C4-M1 O2-M1 F3, C3, O1 ve M2 derivasyonları yedek olarak yerleştirilmeli), 2. Elektrookülagrafi (EOG) derivasyonları (2 derivasyon), 3. Yüzeyel çene elektromiyografi (EMG) derivasyonları (1 derivasyon), 4. Yüzeyel bacak EMG derivasyonları (2 derivasyon), 5. Hava yolu sinyalleri (2 derivasyon), 6. Solunum eforu sinyalleri (2 derivasyon), 7. Oksijen satürasyonu, 8. Vücut pozisyonu, 9. Elektrokardiyografi (EKG).

PSG'nin nörofizyolojik izleminde kullanılan temel kanallardan; EEG; Uykunun, uyanıklığın ve uyku esnasında gelişen elektriksel aktivitedeki değişikliklerin objektif olarak gösterilmesini sağlar. EOG; NonREM (NREM) evre-1 uykusundaki yavaş dairesel göz hareketlerinin ve REM uykusundaki hızlı göz hareketlerinin tespit edilmesinde kullanılır. EMG; uykunun farklı evrelerinde ve istirahat halindeki kas tonüsünü özellikle de REM uykusu dönemindeki kas atonisini göstermede kullanılır. PSG de solunumsal izlem, uykuda gelişen solunum bozuklukların tanısında kullanılır. Hastanın solunumsal açıdan takibinde thermistör, oro-nazal akım ölçer (nazal kanül), pnömotakograf ile ölçülen oronazal hava akımı, göğüs ve karına yerleştirilen kemerler aracılığıyla takip edilen torakoabdominal hareketler, pulse oksimetre ile tüm gece boyunca oksijen satürasyonu takibi yapılarak ölçülen oksijenasyon ve larenks düzeyinde, sternokleidomastoid kasının 1/3 orta ön kısmına yerleştirilen minyatür mikrofonlar aracılığıyla kaydedilen horlama sesi rutinde kullanılır. Hastanın solunumsal açıdan takibinde kullanılan diğer yöntemler, CO2 ölçümü, özefagus basıncı takibi, pulse transit time incelemeleridir. PSG'de kardiyovasküler izlem uyku süresi boyunca elektrokardiografik kayıt elde edilebilir. Genellikle tek kanal (D2) EKG genellikle yeterlidir. PSG'de ölçülen diğer parametreler; vücut pozisyonu, kol-bacak hareketleri, nokturnal penil tümesans, özefageal pH İzlenmesi, vücut Isısı, ses ve video kayıtlarıdır.

Elektrotların yerleştirilmesinden sonra kalibrasyon yapılarak elektrotların sinyal iletimi kontrol edilir. Kalibrasyon sırasında kaydedilen sinyali vurgulamak ve istenmeyen sinyalin amplitüdünü azaltmak için filtreleme işlemi uygulanır. Kayıt yapılırken; PSG kayıt hızı 10 mm/sn olmalıdır, epok (sayfa) 30 sn tercih edilir, 6–8 saatlik bir kayıt alınmalıdır, en az 16 kanallı polisomnograf kullanılmalıdır.

PSG'de elektrot montajının son kısmı biyokalibrasyondur. Skorlama sırasında özelikle göreceli olan verilerin (EMG, hava akımı) değerlendirilmesinde önemlidir. Montaj bitip kaydın sorunsuz olduğu anlaşıldığında hastaya biyokalibrasyon sırasında belli komutlar verilerek (Gözleri açıp kapama, sağa/sola/yukarı/aşağı bakma, göz kapaklarını kırpma, dişleri sıkma, nefes alıp verme, nefesi tutma, bacakları hareket ettirme) elektrotların sinyal iletimi kontrol edilir.

PSG çalışmalarında, termistör/termocouple, nasal kanül, göğüs ve karın solunum kemerleri, vücut posizyon sensörü, horlama sensörü, pulse oksimetre, yapıştırıcı bantlar (transpore, hypafix, medipore) hava kompresörü, kollodium, alkol/asetonlu cilt temizleyicileri, EEG pastası, mezüre, yağlı kalem, saç klipsleri, tarak, gazlı bez (spanç) EEG elektrotları, EKG elektrotları gibi bir çok sarf malzemesi kullanılmaktadır.

PSG, gerek uykuyu gerekse bozukluklarını anlama ve uyku bozukluklarının incelenmesi için önemli bir

araç olup eğitimli teknisyenler tarafından uygulanması gereken karmaşık bir prosedürdür. PSG işlemine hazırlanan her hasta için test öncesi, testin yapılacağı gün ve işlemden sonra yapılması gereken birtakım işlemler vardır. Teste gelmeden önce randevu formunun dikkatlice okunması ve burada belirtilen kurallara uyması hastaya hatırlatılır. Hastaya randevu verilirken testin yapılacağı mekan, yapılacak işlemin süresi-niteliği hakkında bilgi verilmesi hastanın teste uyumunu artıracaktır. Hasta, PSG tetkiki için; saat 19:00 sularında uyku laboratuvarına kabul edilir, hasta odasına yerleşip, pijamalarını giydikten sonra çekim için hazırlıklara başlanır. İşlem öncesi: Her hasta mutlak doktor muayenesinden geçmeli, şüphelenilen hastalıklar için gerekli biyokimyasal ve laboratuvar tetkikleri yapılmalıdır. Hastaların yapılacak işlem hakkında bilgilendirilmesi ve işlemle ilgili bilgilendirilmiş onam formu alınmalıdır. Uyku bozukluklarına yönelik anketler, yakınmalar, özgeçmiş, eşlik eden hastalıklar, kullandığı ilaçlar, uyku alışkanlıkları vs. belirlenir. Sistemik muayenede özellikle fizik muayene, vücut ağırlığı, boy, boyun çevresi ölçülür. Ayrıntılı üst solunum yolu muayenesi için KBB doktorlarından konsültasyon planlanır. Testin ne zaman yapılacağı, ne kadar süreceği ile ilgili açıklamalarda bulunur. Testin yapılacağı gün: Hastanın tetkikin yapılacağı günü olağandan farklı geçirmemesi, bir gece otelde uyuyacakmış gibi hazırlanarak, uyku merkezine genelde akşam saatlerinde gelmesi istenir. Montaj işlemine başlamadan önce uyku laboratuvarı ortamına alışması için bu süre gereklidir. Hastanın kayıt sırasında oluşabilecek artefaktların önlenmesi amacı ile banyo yapması, traş olması, oje sürmemesi istenir. Hasta konforu için pijama, eşofman, terlik, diş fırçası gibi tuvalet malzemelerini yanında getirmesi, özellikle o gün içinde uykusunu etkileyebilecek kafeinli ve alkollü içkiler içmemesi, ağır egzersiz yapmaması, günlük yaşantısını bozmaması ile ilgili önerilerde bulunulur. Tüm bunlarla ilgili detaylı bilgilerin olduğu, uyku merkezi ile ilgili telefon numaralarının bulunduğu ve üstünde randevu tarihi ve saatinin yazdığı randevu formunun hastalara verilmesi işleri kolaylaştırmaktadır. İşlem gecesi ve sonrası: son 10 günde aldığı ilaçlar ve işlem günü yaşadığı tetkiki etkileyebilecek özel bir durum olup olmadığı sorulur. Hasta işleme hazırlanır. İşlem sırasında montaj ile ilgili oluşan teknik ve hasta ile ilgili diğer bilinmesi gereken hususlar teknisyen tarafından not edilir. İşlem sonrası ertesi sabah personel ile ilgili bilgi, gece laboratuvarda olan olaylar ve uykusunun nasıl olduğu ile ilgili soruların olduğu uyku sonrası form hastaya doldurtulduktan sonra hasta uyku merkezinden taburcu edilir.

SLEEP STAGİNG RULES

Dr. Sinan Yetkin

Sleep scoring is the process of extracting sleep cycle information from the electrophysiological signals. Sleep stages are described by three bio-signals; electroencephalogram (EEG), electrooculogram (EOG), and chin electromyographic activity (EMG). The American Academy of Sleep Medicine (AASM) scoring manual rules are used for scoring and expanded of other physiological events. This manual also provides a methodology to standardize sleep recording. The AASM scoring manual recognizes four sleep stages: Stage N1, stage N2, stage N3, and stage R sleep (REM sleep). According to the AASM manual, a minimum of three EEG derivations, sampling activity from the frontal, central, and occipital regions, has to be recorded. The recommended derivations are F4-M1, C4-M1, and O2-M1. The manual also deals with the definition of the sleep-wake transition, sleep spindles, K-complexes, slow wave sleep, and REM sleep, as well as arousals and major body movements. Sleep stages should not be viewed as distinct entities, but rather as a gradual transition of a waveform. The scoring rules were devised to allow uniformity between sleep laboratories and to offer a conceptual simplicity rather than a rigid framework. In this presentation will include a discussion of the specific sleep EEG waveforms required for staging sleep and a summary of staging rules. The discussion will be followed by a discussion of the stages of sleep using specific polysomnographic records.

LEG MOVEMENTS AND OTHER MOVEMENT RECORDİNGS, DEFİNİTİONS AND TECHNİQUES, MOVEMENT SCORİNG RULES

Esra Ünverdi Bıçakcı
SBÜ Gülhane Eğitim ve Araştırma Hastanesi

Sleep-related movement disorders may be defined as simple and stereotypical movements that occur at the beginning of sleep or the later stages, which prevent in initiation or continuation of sleep. Movements that occur in a part of the body during sleep may be a symptom of a specific disease, while they may be in benign conditions that do not require treatment. These movements that occur during sleep can be diagnosed by polysomnography. By using polysomnography both the diagnosis and the severity of the illness can be identified and also the effects of the therapy on the severity of the disease can be determined. According to the American Academy of Sleep Medicine (AASM) V2.6, periodic leg movements (PLM), alternating leg muscle activation (ALMA), hypnagogic foot tremor (HFT), excessive fragmentary myoclonia (EFM), bruxism, REM without atonia (RWA), and rhythmic movement disorder scoring rules were determined. In this presentation, leg movements and other movement recordings, definitions and techniques, movement scoring rules will be explained during sleep.

References

1. Kadir D, Seden D, (2016), Uyku ile ilişkili hareket bozuklukları. Uyku Bozuklukları Tanı ve Tedavi Kitabı, 1. Baskı, Erhan A, Fatma Özlem O, Mehmet Murat D (Ed), Ankara, Türk Psikiyatri Derneği Yayınları, s. 135-43.
2. American Academy of Sleep Medicine (AASM) (2014) International classification of sleep disorders, 3 rd ed (ICSD-3). Darien, IL: American Academy of Sleep Medicine

POLYSOMNOGRAPHY, PORTABLE MONİTORİNG, AND ACTİGRAPHY

Mehmet Koçer
Gulhane Training and Research Hospital

Polysomnography (PSG) is a sleep study performed overnight while being continuously monitored by a technician. PSG study determine structure of sleep, psychological and pathological changes in sleep and examine in relation with sleep stages. The PSG monitors many physiological functions, including brain activity, eye movement, muscle activity, respiratuar effort and rhythm of heart . PSG is a gold standart test for sleep-related breathing disorders, and it is also used to diagnose a variety of additional sleep disorders, including narcolepsy, sleep-related movement disorders, and complicated parasomnias. PSG is also indicated to determine the efficacy of surgical treatment and determine the efficacy of oral appliance (OA) treatment . PSG is not indicated for the restless legs syndrome, insomnia, uncomplicated parasomnias, or a patient doing well on CPAP treatment.

There is a classification of monitoring devices for the diagnosis of obstructive sleep apnea (OSA). Current terminology is “type 1, 2, 3, and 4” device. Type 2,3,4 devices are named Portable Monitoring Devices. Portable Devices recommend monitoring at a minimum airflow, respiratory effort, and SaO2. Some selected patients, the diagnostic evaluation for obstructive sleep apnea (OSA) may be performed at home without a technician in attendance. Home sleep apnea testing is only useful for the diagnosis of OSA in selected patients; İt is not apropriate for other sleep disorders are suspected.

Actigraphy is another method of measuring sleep parameters. Actigraphy used for evaluate sleep patterns in patient with insomnia and diagnosis of circadian rhythm disorders. Also if PSG is not available, actigraphy is indicated to estimate Total Sleep Time (TST) in patients with OSA.

In this presentation, we aim to inform you about the differences between PSG and portable polysomnography and the indications for use of actigraphy.

References

1. Berry, R.. (2012). Fundamentals of Sleep Medicine. Fundamentals of Sleep Medicine.p 189-218.
2. Standards of Practice Committee of the American Sleep Disorders Association, Practice Parameters for the Use of Portable Recording in the Assessment of Obstructive Sleep Apnea, Sleep, Volume 17, Issue 4, June 1994, Pages 372–377
3. Morgenthaler T, Alessi C, Friedman L, et al: Practice parameters for the use of actigraphy in the assessment of sleep and sleep disorders: an update for 2007. Sleep 2007;30:519–529.

TRAVMAYI KADINCA YENİDEN YAZMAK, YARATICI YAZI ATÖLYE ÇALIŞMASI

Ayla Türksoy

Travma; kayıp, afet, şiddet, yoksulluk, cinsel istismar gibi birçok zor olguyu içinde barındıran bir kavram. Yapılan çalışmalar travmadan etkilenen bireylerin bu zor süreçle başa çıkmada başarısız olduğu durumlarda; yaşamına devam etmekte güçlük yaşadığını, uyum güçlüğü çektiğini, kimi zaman öfkeli hırçın, kimi zaman edilgen ve sessiz, ama çoğunlukla tedirgin bir kişi hale geldiğini gösteriyor. Bu süreç aylar, yıllar boyunca, bazen bir yaşam boyu sürebiliyor. Kimi zaman, travmanın etkisiyle yaşanamamış çocukluk ve yetişkinlik, dünyaya ve insanlara güven kaybı gibi etkileriyle travma; Judith Herman'ın deyimiyle "sessizliğin güçsüzlük acısı" olarak kişinin yaşamına damgasını vuruyor.

Başta bireysel ve sosyal ilişki ağları, destek, dayanışma, ve psikiyatri uygulamalarının yanında, sanat ve çeşitli sanatsal yaklaşımlar, "travmaya uğramış sessiz bireyin" duygularını fark etmesi, bunları paylaşması, giderek konuşan ve travmasını dile döken bir özne haline gelmesi ve travmanın işlenip anlamlandırılmasının bir sonucu olarak bireyin normal yaşamına dönmesi açısından son derece önemli araçlar olarak gösteriliyor.

Gerçekleştireceğimiz "Travmayı Kadınca Yeniden Yazmak" yaratıcı yazı atölye çalışmasında, ataerkil düzen içinde çoğunlukla bastırılması istenen, unutuluşa terk edilen, ancak kimi zaman tıpkı bir şimşek çakması gibi kendini anımsatan ve kişinin dünyayla ilişkilerini bozan; hapsolmuş kötü yaşantılarını yazı diline dönüştüren, travmanın dile dökülmesini iyileşme sürecinde kullanan ve bireysel örselenmişliklerini yazı diline aktaran bazı kadın yazarların eserlerine de değinerek, kurgusal ya da gerçek, kadın olarak kendi başımıza gelen ya da başkasının yaşadığı, tanık olduğumuz örselenmişlikleri, travmayı konuşmanın, aktarmanın yarattığı sağaltımı; travmaya edebi, psikolojik ve felsefi boyutlardan bakışın; düşünce ve duyguların yazarak aktarılmasının güçlendirici

References

1. Judith Herman., Travma ve İyileşme. 9. Baskı, Literatür Yayınları, İstanbul, 2021.
2. Gülayşe Koçak., Yaratıcı Yazmanın Hazzı. 2. Baskı, Alfa Yayınları, İstanbul, 2018.
3. Joanna Russ., Yazmak Yasak: Bastırılan Kadın Yazını. Minotor Kitap, İstanbul, 2022.
4. Fatmagül Berktay., Tarihin Cinsiyeti. 6. Basm, Metis Yayınları, İstanbul, 2018.
5. Gayatri Chakravorty Spivak., Madun Konuşabilir mi? Dipnot Yanları, Ankara, 2020.
6. Susan Sontag., Metafor Olarak Hastalık. 3. Baskı, Can Yayınları, İstanbul, 2021.
7. Hilmi Tezgör, Aslan Erdem., Bahçelerinde Yaz: Füruzan Edebiyatı Üzerine, Yap Kredi Yayınları, İstanbul, 2021.

EMDR KURSU-EMDR PSİKOTERAPİSİ NEDİR? ADAPTİF BİLGİ İŞLEME SÜRECİ NEDİR? EMDR NASIL UYGULANIR?

Dursun Hakan Delibaş

Desensitization and Reprocessing with Eye Movements (EMDR) is a type of psychotherapy originally designed to alleviate distress associated with traumatic memories (1). Shapiro's Adaptive Computing model, the first theorist of psychotherapy, suggests that EMDR therapy makes it easier to access traumatic memories and other negative life experiences and process them to bring them to an adaptive solution. After successful treatment with EMDR therapy, emotional distress is eliminated, negative beliefs are re-formulated and physiological arousal decreases. During EMDR therapy, the client is asked to remember the emotionally uncomfortable memory in short sequence doses, while focusing on an external stimulus at the same time. Lateral eye movements guided by the therapist are the most commonly used external stimuli, but various other stimuli such as manual touch and auditory stimuli are often used. Shapiro assumes that EMDR therapy facilitates access to the traumatic memory network, thereby improving information processing with new connotations created between traumatic memory and more adaptive memories or information. These new connotations are thought to result in complete information processing, new learning, elimination of emotional distress and the development of cognitive insights. EMDR therapy uses a three-way protocol: (1) past events that lay the groundwork for dysfunction are processed, creating new connotational connections with adaptive information; (2) distressing current conditions are targeted and internal and external triggers are desensitized; (3) Imaginary templates of future events are worked with EMDR to help the client acquire the skills necessary for adaptive functionality (1).

In some diseases as a result of adverse life events with EMDR therapy; symptoms such as post-traumatic stress disorder, phobia, acute stress, as well as direct memory and symptoms are decreasing. Without the individual's awareness, the symptoms of indirectly related mental illness (such as migraines, depression, fibromyalgia...) are reduced. However, there is not yet sufficient scientific evidence for its use in these mental illnesses (2) Emdr Therapy has been proven effective for post-traumatic stress disorder (PTSD) and other trauma-related disorders. It is recommended as a priority in many international treatment guidelines. Reductions in other accompanying symptoms during the administration of EMDR in PTSD and other annealing-related disorders (e.g. years of headaches in a group of victims of terrorist attacks or improvements in depressive symptoms as well as signs of trauma...) It paved the way for emdr to be applied in other mental illnesses.It is recommended as a priority in many international treatment guidelines. Reductions in other accompanying symptoms during the administration of EMDR in PTSD and other annealing-related disorders (e.g. years of headaches in a group of victims of terrorist attacks or improvements in depressive symptoms as well as signs of trauma...) It paved the way for emdr to be applied in other mental illnesses. Evidence-based data on the efficacy of EMDR in mental illnesses other than PTSD and other trauma-related disorders is increasing day by day (3).

In this course; What is EMDR psychotherapy? How is it effective and how is it applied? What is an adaptive information processing model? It is aimed to share 8 stages that are monitored during emdr application. Participants will be able to learn about EMDR psychotherapy and how it is applied.

References

1. https://www.emdr.com, 2021
2. Cuijpers P, Veen SCV, Sijbrandij M, Yoder W, Cristea IA. Eye movement desensitization and reprocessing for mental health problems: a systematic review and meta-analysis. Cogn Behav Ther. 2020;49(3):165-180. doi:10.1080/16506073.2019.1703801
3. Schrader C, Ross A. A Review of PTSD and Current Treatment Strategies. Mo Med. 2021;118(6):546-551.

TRANSDİAGNOSTİC COGNİTİVE BEHAVİORAL THERAPY APPLİCATİONS

Sedat Batmaz

Department of Psychology, Faculty of Social Sciences and Humanities, Social Sciences University of Ankara, Ankara, Turkey

The fact that there are many limitations of the current classification systems led to the emergence of transdiagnostic approaches (TA) that focus on the common psychopathological processes underlying disorders rather than categorical diagnoses. TA focuses on the underlying common psychopathological processes in the emergence and persistence of mental disorders. Thus, even if the disorders are categorically diagnosed differently, it can be determined how they overlap with or separate from each other. TA aims to treat mental disorders using these aspects. TA has a flexible and modular structure that can be easily integrated into cognitive behavioral therapies.

The rest of this course will focus on the Unified Protocol (UP), one of the most popular TA examples. The main purpose of the UP is to enable patients to recognize their feelings and give more adaptive reactions to their negative emotions. Accordingly, UP consists of eight modules. In module 1, the main purpose is to increase motivation and to determine the goals of the treatment. Module 2 focuses on psychoeducation, in which case conceptualization is completed. Module 3 is about mindfulness. In module 4, cognitive interventions are applied. Module 5 deals with all forms of avoidance. Module 6 is mostly about somatic sensations and interoceptive exposure. Exposure is also the main focus of module 7. The last module consists of relapse prevention applications. The modules can usually be completed in a total of 11 - 17 weeks. Each 50 to 60-minute individual session is held once a week. If necessary, changes can be made to the number or the frequency of sessions allocated to modules. The goals of each module of the UP and the treatment approaches towards these goals allow a very clearly defined approach. For this reason, there is a need for a detailed evaluation, conceptualization and treatment plan before the UP is put into practice. We hope that mental health professionals from Turkey will contribute to the developments in the UP.

References

1. Barlow, D., H., Farchione, T., J., Fairholme, C., P., Ellard, K., K., Boisseau, C., L., Allen, L., B., Ehrenreich-May, J. (2011). Unified Protocol for Transdiagnostic Treatment of Emotional Disorders: Therapist guide. Oxford University Press.
2. Barlow, D., H., Farchione, T. J. (2018). Applications of the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders. Oxford University Press.
3. Mansell, W., Carey, T., A., Tai, S. (2012). A Transdiagnostic approach to CBT using method of levels therapy. Routledge.

IS A NATIONAL BIPOLAR COHORT POSSIBLE? TUBIKO PROJECT

Mete Ercis
Istanbul University, Istanbul Medical Faculty, Psychiatry Department

Bipolar disorder is a chronic, complex, and dynamic mental illness that and requires lifelong treatment. Although there have been substantial improvement in the diagnosis and treatment of many psychiatric disorders in the last century, including bipolar disorder, it is still challenging to predict treatment response or the prognosis of individuals neither by clinical features, biochemical or genetic tests, or neuroimaging. Longitudinal follow-up studies emerge as a useful method in order to delineate the risk factors, to predict treatment outcomes and evaluate the role of gene-environment interactions (McInnis et al. 2022).

To date, there have been many multi-site interventional and naturalistic cohort studies in patients with bipolar disorder. Systematic Treatment Enhancement (STEP-BD), The Stanley Foundation Bipolar treatment outcome Network (SFBN), later changed its name to Bipolar Collaboration Network (BCN), FondaMental Advanced Center of Expertise – Bipolar Disorder (FACE-BD), The Heinz C. Prechter Longitudinal Study of Bipolar Disorder Program for Bipolar Disorder (PrBP) and Dutch Bipolar Cohort (DBC) are only a few of them (Jeon et al. 2016). These studies were not randomized placebo-controlled studies, yet they provided extensive information on treatment outcomes and influenced the treatment guidelines. When data are collected in multiple centers and in a prospective manner, the risk of bias is reduced thus increasing the quality of evidence. Such research, whether related to biomarkers or drug efficacy, could be key to understanding bipolar disorder.

In 2004, a computer-based registry program (SKIP-TURK) was designed by Mood Disorders Study Group of Psychiatric Association of Turkey (Özerdem et al. 2004). This program served a base to collect individual patient data nationally in a secure system to give way to retrospective, prospective and cross-sectional studies, however, over the years this program has become inactive. Although it may seem discouraging that the SKIP-TURK is not in use currently, the Turkey Bipolar Disorder Cohort ("Türkiye Bipolar Bozukluk Kohortu", TuBiKo) project can be considered a new step toward planning multicenter longitudinal follow-up studies modified according to today's healthcare system in Turkey. The aim of the TuBiKo project is not to change the registration system used by the different clinics and to create a single registration and follow-up forms, but to determine the minimum requirements of the information each clinic should collect from the bipolar patients they follow. With this protocol, it will be possible to collect data for both clinical use for the treatment of patients and for prospective follow-up studies in a standardized way. A modified Delphi technique was used to determine which data are appropriate and necessary to collect for every clinic that would like to participate in forthcoming collaborative research projects.

After presenting an overview of a variety of bipolar disorder cohorts around the world, the scope of the TuBiKo project, the method used, and its initial results are discussed in detail.

References

1. Jeon HJ, Baek JH, Ahn YM, et al (2016) Review of Cohort Studies for Mood Disorders. Psychiatry Investig. 2016;13(3):265-276. doi:10.4306/pi.2016.13.3.265
2. McInnis MG, Andreassen OA, Andreazza AC, et al (2022) Strategies and foundations for scientific discovery in longitudinal studies of bipolar disorder [published online ahead of print, 2022 Mar 4]. Bipolar Disord. 2022;10.1111/bdi.13198. doi:10.1111/bdi.13198
3. Özerdem A, Yazıcı O, Oral ET et al (2004) Establishment of a registry program for bipolar illness in Turkey. International Society of Affective Disorders 2nd Biennial Conference-Cancun, Mexico, J Affective Disord, 78 (Suppl 1): 86.

DIAGNOSIS AND TREATMENT IN DIFFICULT CASES ONE CASE TWO ORIENTATIONS: SCHEMA THERAPY AND PSYCHODYNAMIC THERAPY SESSION

Prof. Dr. Esra Yancar Demir
Avrasya Üniversitesi, Fen-Edebiyat Fakültesi, Psikoloji Anabilim Dalı, Trabzon

According to Jeffrey Young, founder of Schema Therapy, early maladaptive schemas are defined as lifelong, pervasive, comprehensive cognitive patterns involving memories, emotions, cognitions, and body sensations about oneself and one's relationships. Young has theorised that a person develops inappropriate behaviours as a reaction to a schema. According to Young behaviours are motivated by schemas but are not a part of it. Schemas usually develop during childhood or adeloscance and are useful for the child to adopt to family and social environment. On the other hand, schemas which are useful in childhood are strict and resistant to change and thus may lead to adaptation problems in the later life periods and may be a source for axis 1 and 2 disorder. Young has pointed out the importance of early life experience for the development of schemas and he suggested that children should be supplied with certain basic emotional needs for growing psychologically healthy and adaptable subjects. These needs are safe binding to others, autonomy, competence and identity perception, expression of feelings and games. When noncompliant schemas are activated usually same scenes with parents during childhood emerges. In this presentation, a female patient with depressive disorder in axis 1 and borderline personality disorder in axis 2 will be formulated according to schema therapy followed by evaluation by another therapist psychodynamically. The purpose is to present the audience the approach of two different methods on the same subject.

???????

Murat Yalçın

Psychodynamic psychotherapies or, in other words, psychoanalytic psychotherapies; It is a treatment method that is based on psychoanalytic theory and methods, but the sessions are face-to-face and less frequently, and therapeutic process is usually terminated in a shorter time than psychoanalysis (Widlöcher 2010). Psychoanalytic theory considers psychic functioning as a whole, therefore it aims to explain both the normal functioning of the psyche and normal and impaired developmental processes. One of the focal points in psychoanalytic work is to understand the individual as a whole, with their strengths and weaknesses. The clinical work aim to understand the individual and developmental history rather than just a symptom, disorder, or developmental outcome. The focus is on the underlying unconscious conflicts and psychic defenses, rather than the symptoms. Past experiences are re-experienced through transference and countertransference between the patient and the therapist with the psychological regression created by the therapy environment. Addressing transference and countertransference is the most fundamental work to understand both the content and the process in the psychotherapeutic context.

In the last decades, psychiatry and psychoanalysis have moved in significantly different directions. Psychiatry has become rich in methodology but conceptually limited by a shift towards biological reductionism. On the contrary, psychoanalysis has been relatively limited in methodology, but rich conceptually (Plakun 2012). Difficult cases, in which treatment resistance is also common, are seen as an important problem in current psychiatric practice, where biological treatments are in the first place. The “difficult patient” arises in part from the limitations of our treatment models and treatment modalities (Plakun 2018). While evaluating the factors that cause treatment resistance in the management of difficult cases, the psychoanalytic approach provides an important clinical contribution in addressing the psychological characteristics of the case and its effect on the treatment process. In a part of this panel, the psychoanalytic approach in the diagnosis and treatment of a difficult psychiatric case with treatment resistance will be discussed.

References

1. Plakun E (2012) Treatment Resistance and Psychodynamic Psychiatry: Concepts Psychiatry Needs from Psychoanalysis. Psychodyn Psychiatry 40: 183-209
2. Plakun E (2018) Psychodynamic Psychiatry, the Biopsychosocial Model, and the Difficult Patient. Psychiatr Clin North Am 42: 237-48
3. Widlöcher D (2010) Distinguishing Psychoanalysis from Psychotherapy. Int J Psychoanal 91: 45-50

THE ROLE OF A PSYCHIATRIST IN THE GENDER AFFIRMATION PROCESS: THE CHANGE WITH TIME IN THE MODELS EMPLOYED

Koray Başar

Department of Psychiatry, Faculty of Medicine, Hacettepe University, Ankara, Turkey

Gender dysphoria (GD) is defined as the distress associated with the incongruence between one's gender and the gender socially assumed to align with the sex assigned at birth and/or primary or secondary sex characteristics (American Psychiatric Association 2013). With GD, the current medical recommendation is the gender affirmation process, which consists of a series of medical interventions, and changes in the gender expression in order to adjust the physical and social characteristics of the person to their gender within the framework of their own understanding and preferences. The condition, although defined among mental disorders for decades, is not considered as psychopathology. The category has been preserved mainly for insurance requirements and research purposes. The classification systems removed the "identity" from the name of the category (DSM 5), and removed it from the mental disorders section (ICD 11,), and both recognized the diversity it presents with in the criteria employed (American Psychiatric Association 2013, World Health Organization 2019).

The duties and responsibilities of the healthcare professional in these processes are defined by international guidelines which are updated regularly. In the most widely accepted model ("Standards of Care") by the World Professionals Association for Transgender Health (WPATH) (Coleman et al 2012), the psychiatrist is the main coordinator of the multidisciplinary work carried out by healthcare professionals. The mental health professional has a key role in the assessment of the individual for medical interventions. This assessment essentially includes the evaluation of the individual's capacity to consent, which may require strengthening in a society with a strict binary understanding of gender, where discrimination and stigmatization prevails. The provision of psychosocial support to the individual is a non-negligible component of the assessment process. Although the interventions follow the request of the individual, both hormonal and surgical interventions require letters of recommendation by mental health professionals. In Turkey, genital gender affirming surgery is legally required for the recognition of the gender, and the judicial permission for this group of surgeries is based on a report by a medical board. With increasing depathologization of the condition, the role of the psychiatrist has been a debate for a long time: it is not clear to what extent the psychiatrist has stepped out of the 'gatekeeper' role.

References:

American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Coleman E, Bockting W, Botzer M et al. (2012) Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7, International Journal of Transgenderism, 13:4, 165-232, DOI: 10.1080/15532739.2011.700873

World Health Organization (2019) International Statistical Classification of Diseases and Related Health Problems (11th ed.) https://icd.who.int/

MENTAL HEALTH SERVICES FOR THOSE ENCOUNTERING WITH INFECTIOUS FACTORS: CREATING A CONSULTATION-LIAISON PSYCHIATRY MODEL

Özen Önen Sertöz
Ege University School of Medicine, İzmir, Turkey

The COVID-19 pandemic has necessitated rapid provision of psychiatric care due to its high contagiousness, fatality, and psychiatric sequelae. In the pandemic, consultation liaison (CL) psychiatrists' experience with mental conditions in medical diseases has brought to the fore their role in patient care and health system. This experience has been a valuable element in recognizing, diagnosing, treating and in-service training of psychiatric conditions related to COVID-19. As in many branches of medicine, consultation liaison psychiatry (CLP) has been forced to make changes in practice according to the needs of the pandemic. Face-to-face on-site assessments were quickly replaced by telepsychiatry practices and were largely successfully implemented. During the andemic, many hospitals have developed new CL models in order to provide the best care and support to patients and healthcare professionals.

In the global epidemic, psychiatrists had to adapt to new roles. Psychiatrists are primarily physicians. For this reason, they provided service in non-psychiatry units when necessary by improving their general medical knowledge during the global epidemic. In addition, psychiatrists informed their patients about COVID-19 and directed them to appropriate treatment units in cooperation with family physicians in primary care. Within psychiatry, CL psychiatrists are accustomed to the roles mentioned above. In global epidemics, CL psychiatrists play an active role in the treatment of mental illnesses, in cooperation and communication with other clinics, and in interventions to increase the resilience of healthcare workers. In the fight against the global epidemic, psychiatrists have played a role in both directing clinical care and research on the psychological effects of the global epidemic.

In psychiatry practice, there have been changes in inpatient services, short-term hospitalizations have been planned, the number of beds has been reduced, a visitor ban has been imposed and services have been carried out in accordance with the conditions of the global epidemic. Telepsychiatry among psychiatric practices has been rapidly accepted and spread all over the world. In a way, we can say that the most notable change in psychiatric care in the world is the spread of telepsychiatry practices. Telepsychiatry has been used not only among psychiatrists, but also among CL psychiatrists and teams responsible for the primary care of COVID-19 patients. There are also situations where telepsychiatry has shortcomings or disadvantages. For example psychiatric treatments like ECT.

In conclusion, each country should try to make CLP services suitable for the global epidemic in line with its own health system, health worker strength and possibilities. Studies are needed to understand which methods and treatments are more applicable and acceptable in global epidemics.

References

1. Shapiro PA, Brahmbhatt K, Caravella R, Erickson J, Everly Jr. G, Giles K, et al. Report of the Academy of Consultation-Liaison Psychiatry Task Force on Lessons Learned From the COVID-19 Pandemic: Executive Summary. J Acad Consult Liaison Psychiatry. 2021; 62:377–86.
2. Cheung SG, Capote J, Fan W, Mishkin AD. Pilot Assessment of Patient and Provider Characteristics Associated With Satisfactory Consultation-Liaison Telepsychiatry Encounters. J Acad Consult Liaison Psychiatry. 2021; 62:582–7.
3. Unutzer J, Kimmel RJ, Snowden M. Psychiatry in the age of COVID-19. World Psychiatry 2020; 19:130–1.

TAU-TARGETING THERAPIES FOR ALZHEIMER'S DISEASE

Bilgen Biçer Kanat

Alzheimer's disease (AD) is a neurodegenerative disorder characterized by loss of memory, cognitive impairment, behavioural changes and loss of functional abilities. AD is the most common cause of dementia and it is estimated that more than 50 million people worldwide have dementia, nowadays. This number is expected to reach over 150 million by 2050. Although the pathogenesis and mechanism of AD progression remain unclear, the two principal neuropathological hallmarks of AD are extracellular deposition of amyloid β (Aβ), in the form of plaques, and intracellular neurofibrillary tangles (NFT) (1). Currently, only four drugs are approved by the Food and Drug Administration (FDA) for the treatment of AD. Three of these are inhibitors of the acetylcholinesterase enzyme (AChE) (donepezil, galantamine and rivastigmine) and one is a N-methyl-D-aspartate (NMDA) receptor antagonist (memantine). However, these drugs only contribute to modest benefits in symptoms management. In addition, they do not prevent neuronal loss, brain atrophy and, consequently, the progressive deterioration of cognition (2). The amyloid cascade hypothesis, since it was formulated in 1992 by Hardy and Higgins, has been the focus of a large number of investigations, but without great success to date. In fact, most of the candidate drugs targeting Aβ have failed to show clinical efficacy in late-stage clinical trials. Consequently, the tau pathology has received more attention in recent years. Drugs targeting tau protein demonstrated positive results in preclinical studies and are now in the early stages of clinical trials (3) The role of tau protein remains not completely understood but studies demonstrated that it has an important function in assembly and stabilization of cytoskeletal microtubules. In addition, it was demonstrated that abnormal hyperphosphorylation of tau (p-tau) reduces its affinity to bind microtubules . This disruption of tau-microtubule link leads to microtubules dysfunction and increases the cytosolic levels of p-tau, with consequent aggregation and formation of NFT. The anti-tau therapies include the prevention of tau hyperphosphorylation and aggregation, microtubule stabilization and the promotion of tau clearance. Currently, the majority of anti-tau therapies in clinical trials are immunotherapies. However, they are in the early stages of clinical research and none of them reached phase III, so far. Data available comes essentially from conferences communication or press releases of study sponsors.

Referances

1. Deture, M.A., Dickson, D.W., 2019. The neuropathological diagnosis of Alzheimer's disease. Mol. Neurodegener. 14, 1–18.
2. Alzheimer's Association, 2020. 2020 Alzheimer's disease facts and figures. Alzheimer's Dementia 391–460
3. Congdon, E.E., Sigurdsson, E.M., 2018. Tau-targeting therapies for Alzheimer disease. Nat. Rev. Neurol. 14, 399–415.

OBEZİTE, BİLİŞ, ÖDÜL VE ORTAK YOLAKLAR

Doç. Dr. Hale Yapıcı Eser

Obezite, sol ve sağ inferior frontal girus, insula, sol orta temporal korteks, presantral girus ve serebellumda beyin gri madde hacmi değişiklikleriyle bağlantılıdır. Ayrıca bilişsel bozukluğu olmayan bireylerde bile miyelin içeriğinde düşme bildirilmiştir. Obezitede beyin enerji yönetimi bozulur. Hayvan modelleri de göstermiştir ki insülin direnci ve inflamasyonun aracı rolü ile kan beyin bariyeri daha geçirgen hale gelir, obez hayvanlarda protein olarak vimentin ve tubulin gibi proteinlerin taşınması azalır ve grelin, leptin ve insülin gibi moleküllerin taşınması bozulur. Obezite tanısı alan bireylerde gözlenen nöropatolojik değişiklikler nöropsikiyatrik işlev bozukluklarıyla bağlantılıdır. Ayrıca, obeziteye ek olarak tip 2 diyabet, obstrüktif uyku apnesi, hipertansiyon, hiperlipidemi, hormonal düzensizlikler, azalan hareketlilik ve artan inflamasyon da özellikler yürütücü işlevler başta olmak üzere bilişsel işlev bozukluklara yol açabilir. Obezite, artan dürtüsellik, azalmış bilişsel esneklik ve yürütücü fonksiyon bozuklukları yanısıra bellek puanlarında daha düşük performans ve görsel-uzaysal yeteneklerde azalma ile de ilişkilidir. Obezite aynı zamanda Alzheimer hastalığına yakalanma riskini de iki kat artırmaktadır. Orta yaşta daha yüksek vücut kitle indeksi, muhtemelen inflamasyon, vasküler disfonksiyon, metabolik bozukluk ve mikrobiyota değişiklikleri yoluyla demansa yol açar. Obezite aynı zamanda anksiyete ve depresyon gibi birçok psikiyatrik bozuklukla ve artmış stres yanıtları ile de ilişkilidir. Obezitenin ruhsal bozukluklar ile çift yönlü bir ilişkisi vardır. Bu birlikteliklerin hem inflamatuar hastalıklar hem de diyabet, hipertansiyon gibi ek tanılar yanısıra mitokondriyal disfonksiyon, genetik mutasyonlar ve artan oksidatif stres ile de ilişkili olduğu düşünülmektedir. Ancak tüm bu bulguların yanısıra obezite hastalarında ödül sistemi ile ilişkili bozukluklar da bildirimiş ve bu yolaktaki bozulmaların, tekrarlayan ağırlık artış ve azalma kısır döngüleri ile ilişkili olabileceği de ileri sürülmüştür. Bu sunumda, Dr. Hale Yapıcı Eser'in direktörü olduğu Koç Ünv. Stres,Duygudurum ve Biliş Laboratuvarı'nın son bulguları üzerinden obezite, biliş ve ödül sistemlerinin ortak yolakları tartışılacaktır.

Obesity, cognition, reward and shared pathways

Obesity is associated with brain gray matter volume changes in the left and right inferior frontal gyrus, insula, left middle temporal cortex, precentral gyrus, and cerebellum. In addition, a decrease in myelin content has been reported even in individuals without cognitive impairment. Brain energy consumption is impaired in obesity. Animal models have also shown that with the mediator role of insulin resistance and inflammation, the blood-brain barrier becomes more permeable, the transport of proteins such as vimentin and tubulin is reduced in obese animals, and the transport of molecules such as ghrelin, leptin and insulin is impaired. Neuropathological changes observed in individuals diagnosed with obesity are associated with neuropsychiatric dysfunctions. In addition to obesity, type 2 diabetes, obstructive sleep apnea, hypertension, hyperlipidemia, hormonal irregularities, decreased mobility and increased inflammation may lead to cognitive dysfunction, especially in executive functions. Obesity is associated with increased impulsivity, and decreased cognitive flexibility, as well as lower performance in memory scores and reduced visuospatial abilities. Obesity also doubles the risk of developing Alzheimer's disease. A higher body mass index in middle age leads to dementia, possibly through inflammation, vascular dysfunction, metabolic disorder, and microbiota changes. Obesity is also associated with many psychiatric disorders such as anxiety and depression, and increased stress responses. Obesity has a bidirectional relationship with mental disorders. These associations are thought to be associated with inflammatory diseases and additional diagnoses such as diabetes and hypertension, as well as mitochondrial dysfunction, genetic mutations and increased oxidative stress. However, in addition to all these findings, disorders related to the reward system have also been reported in obesity patients, and it has been suggested that disruptions in this pathway may be associated with recurrent vicious cycles of weight gain and decrease. In this presentation, Dr. Hale Yapıcı Eser will be discussing the common pathways of obesity, cognition and reward systems, in the light of the latest findings of the Koç University Stress, Mood and Cognition Laboratory, that she leads.

Referanslar

Herrmann MJ, Tesar AK, Beier J, Berg M, Warrings B. Grey matter alterations in obesity: A meta-analysis of whole-brain studies. Obesity reviews. 2019 Mar;20(3):464-71.

Spyridaki EC, Avgoustinaki PD, Margioris AN. Obesity, inflammation and cognition. Current Opinion in Behavioral Sciences. 2016 Jun 1;9:169-75.

Prickett C, Brennan L, Stolwyk R. Examining the relationship between obesity and cognitive function: a systematic literature review. Obesity research & clinical practice. 2015 Mar 1;9(2):93-113.

Bhat ZF, Morton JD, Mason S, Bekhit AE, Bhat HF. Obesity and neurological disorders: dietary perspective of a global menace. Critical reviews in food science and nutrition. 2019 Apr 28;59(8):1294-310.

MOOD DISORDERS AND REPAIR OF GENOMIC DAMAGE

Deniz Ceylan

Mood disorders are chronic, severe and disabling psychiatric disorders associated with increased morbidity with general medical conditions including cardiovascular, metabolic or inflammatory diseases (1,2). Despite molecular mechanisms underlying mood disorders are largely unknown, emerging evidence suggests multiple biological pathways, including oxidative stress, HPA abnormalities, inflammatory dysregulation, mitochondrial dysfunction, as shared mechanisms between mood disorders and systemic diseases (1,2). Compiling evidence shows involvement of increased oxidative stress and oxidative damage to DNA in mood disorders, and indicates possible abnormalities in DNA repair processes in mood disorders (3).

Oxidative stress refers to an imbalance between the production and neutralization of free radicals in favor of production (4). It is a major cause of DNA damage of various types for various mechanisms. DNA damage is involved in vulnerability to various cancers, several degenerative diseases, neurocognitive impairment and early aging all of which are common in mood disorders. Oxidative stress and DNA damage are suggested as potential mechanisms underlying the pathophysiology of mood disorders and as contributory mechanisms to the increased medical comorbidity and early aging in mood disorders.

Recent years have witnessed an increase in studies regarding the role of DNA repair enzymes in mood disorders (5). Results of the meta-analysis studies showed elevated levels of oxidative DNA damage in mood disorders (3). Recent data highlights involvement of the DNA repair mechanisms in mood disorders across different states of illness and in response to treatment introducing new potential biomarkers for illness progress and perhaps treatment opportunities.

The aim of this symposium is to review the recent data on oxidative damage to DNA and repair mechanism in mood disorders. Exploring new molecular targets towards new treatment options for mood disorders will be the highlight of presentations. Finally, the clinical implications and future directions will be discussed.

References

1. Grande I, Berk M, Birmaher B, Vieta E. Bipolar disorder [Internet]. C. 387, The Lancet. 2016 [kaynak 15 Haziran 2019]. s. 1561–72. Available at: https://linkinghub.elsevier.com/retrieve/pii/S014067361500241X
2. Malhi GS, Mann JJ. Depression. C. 392, The Lancet. Lancet Publishing Group; 2018. s. 2299–312.
3. Özerdem A, Ceylan D. DNA damage and repair mechanisms in bipolar disorder. Içinde: Biomarkers in Bipolar Disorders. Academic Press; 2022. s. 361–83.
4. Özerdem A, Ceylan D. Neurooxidative and neuronitrosative mechanisms in bipolar disorder: Evidence and implications. Neurobiol Bipolar Disord. 01 Ocak 2021;71–83.
5. Kucuker MU, Ozerdem A, Ceylan D, Cabello-Arreola A, Ho AMC, Joseph B, vd. The role of base excision repair in major depressive disorder and bipolar disorder. J Affect Disord [Internet]. 16 Mart 2022 [kaynak 24 Mart 2022]; Available at: https://pubmed.ncbi.nlm.nih.gov/35306122/

PROVISION OF MENTAL HEALTH SERVICES FOR SENSITIVE GROUPS DURING THE PANDEMIC

Özlem Kuman Tunçel

Ege Üniversitesi Tıp Fakültesi Ruh Sağlığı ve Hastalıkları AD.

During the pandemic, although almost all individuals are affected mentally worldwide, the level of the impact varies depending on the people's social and economic position in society and their physical status. Psychologically vulnerable groups who are affected more can be summarized as the ones who are exposed to prejudice, discrimination, and isolation due to identities based on gender, ethnicity, sexual orientation, or disability, and those at the bottom of the economic pyramid. Those having physical or psychiatric illness before the pandemic, children, adolescents, elderlies, pregnants, individuals with economic problems, women and children who are exposed to domestic violence, prisoners, migrants, and refugees are some of these vulnerable groups. This panel will address mentally vulnerable groups during the pandemic related to new coronavirus disease (COVID-19) and the actions that should be taken to target those groups. As human psychology cannot be evaluated apart from its biological and social status, inevitably, the recommendations that exist to protect or improve the mental health of these vulnerable groups are related to social policies. Preventing psychological problems during the pandemic can be provided by the effective support of both individuals and the community. This is not a situation that only the health sector can achieve alone. Vulnerable groups and their needs should be determined by conducting general population screenings during the pandemic period; policies to meet these needs should be developed promptly and put into action. Encouraging social cooperation towards vulnerable groups will improve the mental health of both vulnerable groups and the whole society and reduce the health system's burden. Social and economic policies to protect the mental health of vulnerable groups should be implemented as soon as possible since it is thought that the pandemic's financial and mental health consequences can have lasting impressions on vulnerable groups. Unfortunately, this will further deepen the inequality that disadvantaged groups are exposed to.

References

1. Kuman Tunçel Ö (2022) Küresel salgın döneminde ruh sağlığı açısından duyarlı gruplar. Piskiyatride Güncel 12 (2): 162-174
2. Patel JA, Nielsen FBH, Badiani AA, Assi S, Unadkat VA, Patel B, Ravindrane R, Wardle H. Poverty (2020) Poverty, inequality and COVID-19: the forgotten vulnerable. Public Health 2020; 183: 110-1
3. Uphoff EP, Lombardo C, Johnston G, Weeks L, Rodgers M, Dawson S, Seymour C, Kousoulis AA, Churchill R (2021) Mental health among healthcare workers and other vulnerable groups during the COVID-19 pandemic and other coronavirus outbreaks: A rapid systematic review. PLoS One 16: e0254821.

KÜRESEL SALGIN VE SONRASINDA RUH SAĞLIĞINI KORUMA VE GELİŞTİRME

Aybeniz Civan Kahve

University of Health Sciences, Ankara City Hospital, Department of Psychiatry, Ankara, Turkey

While the fight against the New Coronavirus Disease (COVID-19) pandemic continues in the world, the effects of the epidemic in social, political, socio-cultural and economic dimensions have become as important as its disease-causing effect. The mental strain experienced with the COVID-19 pandemic, in relation to all components of the epidemic, affected not only the infected or those in quarantine, but also individuals in the general population. The pandemic, which expresses an extraordinary situation, emerged unexpectedly, bringing social isolation and loneliness with it. Individuals were faced with the fear of suddenly becoming sick, infecting the disease, and losing their loved ones. Moreover, the ongoing uncertainty regarding the course and treatment of the disease due to the nature of the disease, the economic difficulties experienced with the protracted process, increased domestic tension and the risk of violence have caused many negative psychological conditions. Even if the infection is brought under control in the upcoming periods, it is not difficult to predict that the mental effects will continue for a long time. A comprehensive understanding of mental health problems in different populations is needed in order to develop policies to protect mental health in this period. Interventions to protect and improve mental health can be possible by understanding the problems and creating a policy to solve them. This policy should be pursued in a multidimensional way, from the socio-economic regulations of the government administration to the training of general health workers and from the content of the information for the general population in the media to a consultancy that will facilitate coping with losses and mourning. Online communication tools and social media, the use of which has increased during the global epidemic, can be used both to form volunteer groups for mental health support and to direct individuals to reliable sources. These platforms seem to be important in protecting and improving mental health, as they provide regular communication with individuals and allow people to share information about their health and resource needs with others.

References

1. Türkiye Psikiyatri Derneği. COVID-19 Tedavisinde Önleyici, Koruyucu ve Tedavi Edici Psikiyatrik Hizmetler. Available at https://psikiyatri.org.tr/2191/covid-19-tedavisinde-onleyici-koruyucu-ve-tedavi-edici-psikiyatrik-hizmetler [Access date, April 09, 2022].
2. Brooks SK, Webster RK, Smith LE, Woodland L, Wessely S, Greenberg N, Rubin GJ. The psychological impact of quarantine and how to reduce it: rapid review of the evidence. The Lancet 2020;395(10227):912-20.
3. Rajkumar RP. COVID-19 and mental health: A review of the existing literature. Asian J Psychiatr 2020;52:102066.
4. Adom D, Mensah JA, Osei M. The psychological distress and mental health disorders from COVID-19 stigmatization in Ghana. Social Sciences & Humanities Open 2021;4(1):100186.

BENZODIAZEPINES AND OTHER GREEN PRESCRIPTION DRUGS (BUSPİRONE, TIANEPTINE, ZOPICLONE)

Prof. Dr. Esra Yancar Demir
Avrasya Üniversitesi, Fen-Edebiyat Fakültesi, Psikoloji Anabilim Dalı, Trabzon

The drugs given with green prescription such as benzodiazepines, tianeptine, zopiklon and buspirone are often used for treatment of psychiatric disorders. Benzodiazepines tend to have less interaction with the other drugs and are less risky when taken overdose. These drugs have been used for their anticonvulsant, anxiolytic and myorelaxant effects. Their benefits are limited to 2 to 4 weeks in anxiety treatment. Benzodiazepines are should be used where they are useful keeping drug abuse in mind. Drug abuse is defined as physiological, behavioural and cognitive alterations which are prioritized to valued behaviours or feelings before the usage of the drug. Drug abuse can be diagnosed if three or more of the symptoms below are present during the past year:

A strong desire to take the drug

Having difficulty controlling drug taking behaviour (starting, stopping or the dosage)

Having withdrawal symptoms

Needing higher doses than previously taken to experience the effect

Increase of time spent to obtain, use and get over the effects of the drug that no time left for other social activities

Continuing to take the drug even after having obvious signs of having hazardous effects such as disturbances in liver function, depressive mood after using the drug or cognitive disfunction.

This presentation covers the points that have to be taken in to account while using these drus in clinical practice.

GABAPENTIN, PREGABALIN AND OTHERS

Prof. Dr. Çiçek Hocaoğlu
Recep Tayyip Erdogan University, Faculty of Medicine, Department of Psychiatry, Rize, TURKEY

Initially offered as anticonvulsants, pregabalin and gabapentin are now increasingly prescribed for a number of clinical conditions, particularly chronic pain, as well as restless legs syndrome, attention-deficit hyperactivity disorder (ADHD), borderline personality disorder, menopausal problems, chronic prostatitis, vertigo, itching disorder, trigeminal neuralgia, insomnia, migraine, and substance abuse (1). These drugs, known as gabapentinoids, reduce the release of presynaptic excitatory neurotransmitters by selectively binding to the $\alpha 2\delta$ subunit of voltage-gated calcium channels in the central nervous system. Although they have low addictive potential at therapeutic doses compared to other drugs, they can be used to achieve euphoric and dissociative effects. In recent years, it has been exposed to many possible side effects due to its widespread use (2). Some pharmacovigilance databases warn of abuse, addiction, life-threatening intoxication, and death from both gabapentinoids (3). In fact, until recently, gabapentinoids were thought to have minimal (pregabalin) or no (gabapentin) abuse risk. However, the issue of gabapentinoid abuse has been highlighted in data from population-based studies involving inmates and people participating in addiction treatment. The first information on pregabalin abuse has been reported from Europe since the 2010s, after the drug's marketing authorization (4). Similarly, there are many case reports of gabapentin abuse, addiction and withdrawal symptoms. The increase in abuse of gabapentinoids can be attributed to a number of factors. Among these factors; expanding indication and increasing off-label use, ease of obtaining large quantities of prescriptions, rapid dose titration schedules, poor potential for abuse among physicians, seeking alternatives to opioids for the treatment of multiple pain types, decreased availability of prescription opioids, relatively inexpensive, and illegal marketing. Gabapentinoids, obtained legally or illegally, can be abused in doses ranging from therapeutic to supratherapeutic. But it typically includes supratherapeutic doses. The common feature of the reported patients; it is used in doses that are much higher than the recommended daily treatment doses, oral use is common, intravenous, rectal, intranasal use may also be possible, rapid onset of effect, rapid tolerance to the drug and rapid onset of withdrawal. The danger and risk of addiction associated with gabapentinoids is lower than with other sedative and psychoactive drugs. However, individuals with current or past substance use disorder and psychiatric comorbidities are at higher risk of abuse (5). Clinicians should evaluate substance use disorder (especially opioid), psychiatric and drug use histories before starting gabapentinoids. In high-risk patients, treatment with gabapentinoids should be avoided or, if indispensable, carefully administered for a limited period of time, with close follow-up and prescription monitoring. When discontinuing treatment, gradual dose reduction should be made to prevent the development of discontinuation syndrome. In recent years, increasing evidence has begun to accumulate regarding the abuse of both pregabalin and gabapentin. Because gabapentinoids play an important role in the treatment of many chronic conditions, current evidence does not indicate that their use should be restricted. Instead, greater attention needs to be given to the safe prescribing of gabapentinoids as well as the identification of signs of abuse and risk factors. Without abuse labeling, patients should be reexamined and risk analyzed. One should be aware of personal predisposition factors and psychiatric comorbidities for addiction. Detailed information in this area is scarce, systematic data collection and analysis is required. Further studies should be performed to identify risk factors for gabapentinoid abuse and to define the abuse propensity in detail. In this presentation, abuse of gabapentinoids will be discussed in the light of current literature.

References

1. Hong JSW, Atkinson LZ, Al-Juffali N ve ark. (2021) Gabapentin and pregabalin in bipolar disorder, anxiety states, and insomnia: Systematic review, meta-analysis, and rationale [published online ahead of print, 2021 Nov 24]. Mol Psychiatry 2021;10.1038/s41380-021-01386-6.
2. Polat CS, Konak HE, Akıncı MG ve ark.(2022) Misuse of gabapentinoids (pregabalin and gabapentin) in patients with neuropathic pain related to spinal cord injury. J Spinal Cord Med 1–6. Advance online publication. https://doi.org/10.1080/10790268.2021.2024709
3. Evoy KE, Sadrameli S, Contreras J ve ark. (2021) Abuse and misuse of pregabalin and gabapentin: A systematic review update. Drugs 81: 125–56.
4. Bonnet U, Scherbaum N (2017) How addictive are gabapentin and pregabalin? A systematic review. Eur Neuropsychopharmacol 27: 1185-1215.
5. Kalk NJ, Chiu CT, Sadoughi R ve ark. (2002) Fatalities associated with gabapentinoids in England (2004-2020) [published online ahead of print, 2022 Apr 18]. Br J Clin Pharmacol 2022;10.1111/bcp.15352. doi:10.1111/bcp.15352

SUICIDE AND AFTERMATH: THE ROLE OF THE MEDIA

Spc. MD Aslı Kayacan
Bolu İzzet Baysal Mental Health and Diseases Hospital

Recent studies indicated that suicide rates have been increasing in many countries over the years. In this regard, suicide is a matter of a great concern to public health which should be paid close attention to it. With the development of technology, mass media, which rapidly involved to human life, has become an crucial part of daily life. The magnitude of impacts of the media on individuals' emotions, behaviors and attitudes has been the subject of many studies. In this respect, the relationship between the phenomenon of suicide and the media should be examined in terms of understanding the dynamics of suicide and preventing it. The result of the studies indicated that the representation of suicide news in a certain way, by encouraging and dramatizing, could be a trigger for suicidal behavior. The 'Werther Effect' is the definition given to the way that the presentation of suicide news in certain forms in the media affects suicide rates due to its imitation and encouraging effect. WHO provided a guide for media workers on how suicide news should be covered in the media (WHO 2000). It is reported that suicide news made by paying attention to these details is important in terms of preventing suicide. For this reason, reporting suicide news in media has been regulated in many countries(1).

While covering suicide news in the media, attention should be paid to announcing the current means of transportation of mental health services and help-lines, providing information about the behavioral symptoms that increase the risk of suicide, and emphasizing that depression is associated with suicidal behavior and its treatment is possible. It is reported that suicide news made by paying attention to these details is important in terms of preventing suicide(2).

References

1. Cengiz SA. Media and Suicidal Behavior. In: İntiharı Anlama ve Müdahale, Temel Kitap. 2019. p. 435–50.
2. Good MS (2001) Suicide and Media. Annals New York Academy of Sciences April, 932:200-221.

STİGMATİZATİON İN MENTAL DİSORDERS: THE ROLE OF MEDİA

Merve Metin MD
Balıkesir Gönen State Hospital

A disparaging, humiliating, contemptuous attitude or bad action toward a person or an event is known as stigma. Negative beliefs and the resulting prejudice are the basis of stigma.These prejudiced behaviors lead to discrimination and exclusion behaviors.

Although stigmatization can show itself in a number of ways and contexts, those with mental disorders have definitely been the most stigmatized and discriminated against since ages. Stigma is a universal problem that has terrible implications, including a decline in self-esteem for people and their relatives, as well as a reduction in quality of life.

The impact of societal attitudes and practices about mental disorders on the fight against mental disorders is an important subject that has been highlighted for many years. Positive attitudes towards mental illnesses relieve patients, accept their illness and increase their participation in the treatment process. Stigma and prejudice, on the other hand, have a negative impact on people with mental illnesses' awareness, treatment seeking behavior, the doctor-patient relationship, and treatment and rehabilitation program compliance.

Mass media, which has a strong persuasion and orientation effect, can be effective on stigma. Mental disorders are recognized in society through written and visual media, which plays a significant role in shaping people's views and behaviors.The media is the primary source of mental disorders concepts and visuals for people who have never directly met psychiatric conditions. Studies have shown the effect of media on individuals in society.From this point of view, the media can be a very useful tool to inform the society about mental illnesses accurately and to reduce stigma. Unfortunately, both studies and observations from our daily lives suggest that the media has a negative attitude toward this topic. Furthermore, content connected to stigmatization in mental diseases has been found to be widespread in social media posts. From this perspective, the media, whereas a valuable and effective resource for properly informing the public concerning mental disorders, currently contains misleading and oftenly misinformed and comments, which not only contributes to stigma, but also contributes to the consolidation of stigma in society.The repercussions of media stigmatization of unsuitable and misleading material, as well as the potential contributions of appropriate posts, will be examined in this session.

References

1. Boke O, Aker S, Aker AA, Sarisoy G, Sahin AR. Schizophrenia in Turkish newspapers. Social Psychiatry and Psychiatric Epidemiology. 2007; 42(6): 457-61.
2. BABI, Dragan, et al. Stigmatization of mentally ill patients through media. Psychiatria Danubina, 2017, 29.suppl. 5: 885-889.
3. Hayward & Jenıfer A. Brıght, P. E. T. E. R. (1997). Stigma and mental illness: A review and critique. Journal of Mental Health, 6(4), 345-354.
4. Robinson, P, Turk, D, Jilka, S, & Cella, M. (2019). Measuring attitudes towards mental health using social media: investigating stigma and trivialisation. Social psychiatry and psychiatric epidemiology, 54(1), 51-58

MEDİA ON THE WAY OF ACCURATE İNFORMATİON

Uzm. Dr. Alper Bülbül

University of Health Sciences, Istanbul Erenkoy Mental Health and Neurological Diseases Training and Research Hospital

The media, especially the media that can be accessed via the internet, is one of the most preferred ways to reach information. Importance of the media is increasing day by day.

Studies have shown that most of the people first do research on the internet when they face health problems. In addition to the advantages of the internet and the media in accessing information, there are also some risks. Internet users may have difficulty in accessing appropriate and high-quality medical information. Studies have shown that there are many wrong and incomplete information on the internet and media. The contents of health messages in the media should be taken into account in all areas, especially in public health, due to their importance and effects in the lives of individuals.

Due to the fact that psychiatric diseases and their symptoms are more subjective than other disease groups and labeling against psychiatric diseases is more frequent, accurate information presentation may need to be more objective, especially in psychiatry. It is particularly important that the contents are objective in definitions of symptoms and when to consult a psychiatrist.

Health literacy is as important as media content in terms of reaching accurate information. Health literacy is the ability to reach, understand, analyze, evaluate and transfer health messages in written, verbal or visual structures (internet, newspaper, radio, television, etc.). Studies on health literacy reveal the necessity of raising awareness of the reader, listener or viewer, who are passive recipients of the messages of health-related texts in the visual, audio and written media. Thus, instead of being a passive receiver in front of the media, the reader, listener or viewer will be able to read the messages of health-related texts in the media, understand the language of the media, reach the level of consciousness to reach the right information with different researches when necessary, and take part in the communication as an active individual.

References

1. Babić, D., Babić, R., Vasilj, I., & Avdibegović, E. (2017). Stigmatization of mentally ill patients through media. Psychiatria Danubina, 29(suppl. 5), 885-889.
2. Akerkar, S. M., Kanitkar, M., & Bichile, L. S. (2005). Use of the Internet as a resource of health information by patients: a clinic-based study in the Indian population. Journal of Postgraduate Medicine, 51(2), 116.
3. Bilişli, Y. (2019). Medya ve sağlık arasındaki sınırları keşfetmek: eleştirel medya sağlığı okuryazarlığı bağlamında sağlık haberlerine yaklaşım. Maltepe Üniversitesi İletişim Fakültesi Dergisi, 5(2), 197-219.

OLGULARLA EMDR

Dursun Hakan Delibaş

Eye movement desensitization and reprocessing (EMDR) is a psychotherapy approach that has been efficacyd through various randomized controlled trials (RCT) in the treatment of post-traumatic stress disorder (PTSD) and other mental disorders. It is thought that the eye movements used in EMDR provide hemispheric transition, establish a distorted balance, desensitize "Frozen" information and provide an integration that involves processing and adaptation. The spread of EMDR, a relatively new approach first introduced by Shaphiro in 1987, in Turkey was with the 1999 earthquake. As a result of increased research on Emdr, a type of psychotherapy that combines psychodynamic, cognitive-behavioral, client-centered, body-based and interactive elements, it has been shown that traumatic events can contribute to the onset of serious mental disorders and worsen their prognosis (1).

The assumption that each disorder has a physiological component is the basis of the assumption that negative life experiences disrupt the biochemical balance of the brain's physical information processing system, and the assumption that this imbalance prevents the information processing process from reaching a solution. Usually, the patient's history is taken and there is a preparatory stage and then the evaluation is made. Then desensitization, installation and placement, body examination, completion and reassessment are performed and terminated respectively. Although it is most commonly used in post-traumatic stress disorder, it has been reported to be effective in the treatment of psychosis, bipolar disorder, unipolar depression, anxiety disorders, substance use disorders, sexual dysfunctions, eating disorders, personality disorders, convergence, dissociation, OCD, panic disorder, phobias, impulse control disorders, somatoform disorders, other trauma-related diseases and migraines and other chronic pains (2). It is also frequently used in oncology patients (2).

It is also used for performance improvement (helping to develop the special skills and behaviors required for healthy functional life) even without disease. RCT research into other accompanying mental problems of EMDR psychotherapy is still limited, but available evidence suggests that EMDR therapy reduces trauma-related symptoms and has an effect on primary disorders by achieving partial symptomatic recovery. It has also been shown that there can be an adjuvant treatment in chronic pain conditions.

In this session of the panel, the EMDR application experience will be shared with case samples.

References

1. Cuijpers P, Veen SCV, Sijbrandij M, Yoder W, Cristea IA. Eye movement desensitization and reprocessing for mental health problems: a systematic review and meta-analysis. Cogn Behav Ther. 2020;49(3):165-180. doi:10.1080/16506073.2019.1703801
2. Haerizadeh M, Sumner JA, Birk JL, Gonzalez C, Heyman-Kantor R, Falzon L, Gershengoren L, Shapiro P, Kronish IM. Interventions for posttraumatic stress disorder symptoms induced by medical events: A systematic review. J Psychosom Res. 2020 Feb;129:109908. doi: 10.1016/j.jpsychores.2019.109908. Epub 2019 Dec 19. PMID: 31884302; PMCID: PMC7580195

PSİKOJENİK KUSMA OLGUSUNDA EMDR

İbrahim Gündoğmuş

Psikojenik kusma, organik bir etyoloji olmaksızın genellikle şiddetli ve tekrarlayan kusma ile ortaya çıkan bir tıbbi durumdur. Klinik pratikte çok sık karşılaşılmayan bu durumun tedavisinde çeşitli farmakolojik, invaziv ve psikoterapi yöntemleri denenmektedir. Psikojenik kusma tedavisinde, kusmanın önlenmesi ve kusmalar arası sürenin uzatılması amaçlanmasına rağmen henüz net bir tedavi yöntemi ortaya koyulmamıştır. Göz Hareketleri ile Duyarsızlaştırma ve Yeniden İşleme (EMDR), psikojenik kusma oluşumunda altta yatan travmatik bir anı varsa, iyi bir tedavi alternatifi düşünülebilir. Fakat bildiğimiz kadarıyla, literatürde kusma vakalarında EMDR'nin etkinliğini gösteren sınırlı sayıda rapor bulunmaktadır. EMDR'ın hızlı etkinliği göz önüne alındığında psikojenik kusma vakalarında yeni bir tedavi tercihi olarak önemli bir yöntem olabileceği düşünülmelidir. Bu nedenle burada psikojenik kusma tedavisinde EMDR'nin klinik etkinliğini ortaya koymak amaçlanmaktadır. On yedi yaşında, bekâr, üniversite öğrencisi, psikiyatrik geçmişi olmayan kadın hasta, 4 yıldır devam eden, haftada 7-10 arası değişen sayıda kusma şikâyeti ile başvurdu. Psikiyatri başvurudundan önce dâhiliye, intaniye, nöroloji ve kulak burun boğaz kliniklerine başvurmuş, yapılan tetkik (tam kan, rutin biyokimya, batın USG, gastrointestinal endoskopi, beyin MR, enfektif ajanlara yönelik araştırmalar vb) ve tedavilere (antiemetik, sedatif ajanlar, protein pompa inhibitörü) rağmen şikâyetlerinde hiçbir değişiklik olmamıştı. Farmakolojik tedavilerden fayda görmemişti. Hastaya şikayetine yönelik olarak görüşme yapıldı. EMDR uygulanmasına karar verilerek 5 seans EMDR uygulandı. Hastanın kusma şikayetleri gerileyerek tamamen sonlandı. Psikojenik kusma organik patoloji olmaksızın yaşam kalitesini olumsuz yönde etkileyen ve tedavisi zor olan önemli bir durumdur. Tedavi seçeneklerinin genişlemesi bu hastalıktan muzdarip bireylerin tedavisi için faydalı olacağı açıktır. Psikojenik kusma vakalarında, semptomun oluşmasına neden olan faktörlerin neler olabileceğini araştırmak önemlidir ve tedavi de bu faktörlerle başa çıkmada etkili olabilecek bir müdahale seçilmelidir. Sonuç olarak; olgumuzda görüldüğü gibi, psikojenik kusma vakalarında EMDR bir tedavi alternatifi olabileceği göz önünde bulundurulmalıdır. Ayrıca klinisyenlerin psikiyatrik bozukluğun arkasındaki muhtemel travmayı ortaya çıkarması ve tedavide kullanmasının önemi bir kez daha gözden geçirilmelidir. EMDR'nin psikojenik kusma üzerine etkisinin daha iyi açıklanabilmesi için örneklem sayısı geniş ve randomize kontrollü çalışmalara ihtiyaç bulunmaktadır.

RECOGNİZİNG AUTİSM SPECTRUM DİSORDER İN ADULTS

Ali Kandeğer

Depertment of Psychiatry, School of Medicine, Selçuk University

Autism spectrum disorder is a neurodevelopmental disorder characterized by restricted, repetitive interests and behaviors and persistent deficits in social communication, and interaction. Recent data suggest that approximately one of every 100 children on “the spectrum”. Although awareness and recognition of autism increase in childhood, there is a “lost generation” who have not been diagnosed in adults with autism. As others see them, individuals with autism also may see themselves as strange, unusual, weird, and atypical. This places an additional social and psychological burden on them. Psychiatric practices in adulthood are lacking in terms of awareness, recognition, and diagnosis of neurodevelopmental disorders. Recent data show that more than half of adults with autism are undiagnosed. There may be a delay in the diagnosis due to individual and environmental reasons, and this increases the negative outcomes associated with autism. Inadequate recognition of autism leads to misdiagnosis as well as underdiagnosis. Individuals with autism can be misdiagnosed as personality disorders, OCD, and psychotic disorders. Additionally, intellectual disability accompanies more than half of individuals with autism, and these two clinical conditions should be well differentiated from each other. As well as intellectual disability, other psychiatric disorders is accompanied at least 70% of autism. It is necessary to know the unique aspects of autism symptoms in adulthood, identify core symptoms, and differentiate other comorbid psychiatric disorders. It is possible to evaluate individuals thought to be on the autism spectrum with structured interviews such as Autism Diagnostic Interview and Autism Diagnostic Observation Schedule and self-report scales such as Autism Spectrum Quotient and Empathy Quotient. In addition to questioning current symptoms, it is important to examine a detailed childhood neurodevelopmental history. In this way, individuals with autism can be properly diagnosed and medical, psychological, and social support mechanisms can be provided more effectively. “For better than never is late.”

References

Bougeard C, Picarel-Blanchot F, Schmid R et al. (2021) Prevalence of Autism Spectrum Disorder and Co-morbidities in Children and Adolescents: A Systematic Literature Review. Front Psychiatry 12: 744709. doi: 10.3389/fpsyt.2021.744709.

Lai M C, Baron-Cohen S (2015) Identifying the lost generation of adults with autism spectrum conditions. Lancet Psychiatry 2: 1013-27.

Lord C, Brugha TS, Charman T et al. (2020) Autism spectrum disorder. Nat Rev Dis Primers 6: 5. doi: 10.1038/s41572-019-0138-4.

PSYCHOPHARMACOLOGİCAL AGENTS AND TREATMENT UPDATES İN AUTİSM SPECTRUM DİSORDER

Assist. Prof. Ece Buyuksandalyacı Tunc
Maltepe University Faculty of Medicine, Department of Psychiatry

Autism spectrum disorder (ASD) is a neurodevelopmental disorder characterized by persistent impairment in mutual social communication and limited, repetitive behavioral patterns. Reported frequencies approach 1% of the population. In addition to the core symptoms, many patients with ASD experience co-occurring psychiatric and behavioral problems such as aggression, self-harm, impulsivity, hyperactivity, anxiety, and mood symptoms. These conditions often hinder treatment and place a heavy burden on patients and caregivers (1).

Despite these advances in early diagnosis and intervention, it has not yet been proven to reverse the core symptoms of autism completely. Currently, the management of individuals with ASD requires a multimodal approach of behavioral, educational, and pharmacological treatments (2). Pharmacological treatments are widely used in individuals with ASD to improve associated ASD symptoms such as irritability and agitation. Medications are also frequently used to treat comorbid psychiatric conditions such as attention deficit and hyperactivity disorder, anxiety, depression, bipolar disorder, and other disorders (3). Antipsychotics, antiepileptics, Antidepressants, Glutamatergic and gamma-aminobutyric acid(GABA) ergic agents, Stimulant drugs, opiate agonists, Cholinergic agents, melatonin, omega-3, and other nutritional agents can be added to the treatment.

Recent studies have shown that 27-40% of youth with ASD take psychotropic drugs. Nevertheless, individuals with ASD tend to respond less favorably to psychotropic medications and experience more severe side effects than their peers without ASD (4). Therefore, clinicians must be aware of current evidence-based pharmacotherapy, its risks, benefits, and updates on recent studies, and provide good guidance to patients and their families. This presentation aims to review pharmacological treatment updates and options used in individuals with ASD.

References

1. Siafis S, Çıray O, Wu H, Schneider-Thoma J, Bighelli I, Krause M, Rodolico A, Ceraso A, Deste G, Huhn M, Fraguas D, San José Cáceres A, Mavridis D, Charman T, Murphy DG, Parellada M, Arango C, Leucht S. Pharmacological and dietary-supplement treatments for autism spectrum disorder: a systematic review and network meta-analysis. Mol Autism. 2022 Mar 4;13(1):10.
2. Yu, Y., Chaulagain, A., Pedersen, S.A. et al. Pharmacotherapy of restricted/repetitive behavior in autism spectrum disorder:a systematic review and meta-analysis. BMC Psychiatry 2020; 20: 121.
3. Ritu Goel, Ji Su Hong, Robert L. Findling & Na Young Ji. An update on pharmacotherapy of autism spectrum disorder in children and adolescents, International Review of Psychiatry, 2018; 30:(1), p 78-95
4. Ji, Na Young, Findling, Robert L. An update on pharmacotherapy for autism spectrum disorder in children and adolescents, Current Opinion in Psychiatry. 2015; 28:(2), p 91-101

PSYCHOSOCİAL APPROACHES İN ADULTS WİTH AUTİSM SPECTRUM DİSORDER

Serhat Tunc, M.D.
Associate Professor of Psychiatry, Yeditepe University, Istanbul, Turkey

Autism Spectrum Disorder (ASD) is common (1:54) and a serious neurodevelopmental disorder with lifelong social dysfunction, lack of communication, and repetitive behavior (1). Social impairment causes poor functional outcomes in people with ASD, even in the lack of a comorbid intellectual disability: increased risks of bullying and school dropout (2), decreased university education, working, independent living, maintaining friendships, romantic relationships (3) and a generally reduced quality of life.

Social anxiety comorbidity is usual (13–29%) (1) and is related to increased avoidance strategies usage, poor social skills, and functioning, and decreased social motivation and participation (4). In addition, social isolation and loneliness are related to increased depressive symptoms and suicidal thoughts in adults with ASD (5).

Social Skills Training (SST) is a group-based intervention that includes a package of behavioral strategies for teaching new skills based on social learning theory (6). Goal setting, role modeling, behavioral rehearsal, positive reinforcement, corrective feedback, and homework assignments to promote the generalization to real world-functioning are encompassed (7). Group-based social skills training was first built for children and adolescents with ASD (4). Parent-reported social responsiveness in children and adolescents was moderately enhanced by SST (8).

Having good social skills and adequate social support is associated with better quality of life and mental health in adults with ASD. Therefore, supporting individuals with ASD in developing and maintaining close and meaningful relationships is one of the most important intervention methods. Social Skills Training for individuals with ASD aims to develop appropriate communication skills in intimate relationships, choose appropriate friends, use humor while communicating, ability to handle discussions with friends and the environment appropriately, use social media be able to communicate correctly, to develop coping skills against negative actions when rejected by peers, mocked, bullied, etc. (9).

There is no effective drug treatment for core symptoms of ASD. Therefore, the psychosocial approach gains importance in this regard. This presentation will discuss psychosocial strategies and their use in individuals with ASD.

References

1. Lai, M. C., Lombardo, M. V., & Baron-Cohen, S. (2014). Autism. Lancet (london, England), 383(9920), 896–910.
2. Neary, P., Gilmore, L., & Ashburner, J. (2015). Post-school needs of young people with high-functioning autism spectrum disorder. Research in Autism Spectrum Disorder, 18, 1–11.
3. Helles, A., Gillberg, C. I., Gillberg, C., & Billstedt, E. (2015). Asperger syndrome in males over two decades: Stability and predictors of diagnosis. Journal of Child Psychology and Psychiatry, and Allied Disciplines, 56(6), 711–718.
4. Spain, D., & Blainey, S. H. (2015). Group social skills interventions for adults with high-functioning autism spectrum disorders: A systematic review. Autism : The International Journal of Research and Practice, 19(7), 874–886.
5. Dubreucq, J., Haesebaert, F., Plasse, J. et al. A Systematic Review and Meta-analysis of Social Skills Training for Adults with Autism Spectrum Disorder. J Autism Dev Disord 52, 1598–1609 (2022).
6. Bandura, A. (1969). Principles of behavior modifcation. Rinehart and Winston.
7. Moody, C. T., & Laugeson, E. A. (2020). Social SKILLS TRAINING IN AUTISM SPECTRUM DISORDER ACROSS THE LIFESPAN. The Psychiatric Clinics of North America, 43(4), 687–699.
8. Gates, J. A., Kang, E., & Lerner, M. D. (2017). Efcacy of group social skills interventions for youth with autism spectrum disorder: A systematic review and meta-analysis. Clinical Psychology Review, 52, 164–181.
9. Soares, E. E., Bausback, K., Beard, C. L., Higinbotham, M., Bunge, E. L., & Gengoux, G. W. (2020). Social Skills Training for Autism Spectrum Disorder: a Meta-analysis of In-person and Technological Interventions. Journal of Technology in Behavioral Science, 6(1), 166–180.

CEZAEVLERİNDE RUH SAĞLIĞI VE ETİK

Mehmet Can Ger

“Önce zarar verme” tıpta temel bir ilkedir. Tıbbın amacı güçlendirme ve iyileştirmedir. Hukuk sisteminin amacı ise önleme, kontrol altında tutma ve cezalandırmadır. Bu iki amaç çelişir. Kamuoyu yasalarını çiğneyenler ve ahlaki değerlere saldırmış olanlara daha iyi olanaklar sunma konusunda isteksizdir. Cezaevi çalışanları, kendilerine ve ailelerine sağladıklarından daha iyi düzeyde olduğunu düşündükleri bir sağlık hizmetinden ötürü tedavi hizmetine olumsuz yaklaşırlar. İstisnalar dışında doktor-hasta ilişkisinde gizlilik esastır, oysa cezaevlerinde iletişimde gizliliği korumak güçtür. Bu kavramlar da sıklıkla cezalandırmanın felsefesiyle çelişir. Cezaevinde, burada yatan bireylerin akıl sağlığı taleplerinden çok güvenlik ihtiyaçlarının karşılanmasına dönük eylemler öncelik taşır. Cezaevi sistemi kurumlarının niteliği bazen psikiyatrlara engel oluşturur ya da psikiyatri uzmanının uygulama çabalarını bir sınır aşımı sorununa dönüştürür. Cezaevi sistemleri uzmanlaşmış sağlık profesyonellerinin ilgisini çekmek ve elde tutmak için yeterli kaynakları sağlamada başarısız olmaktadır. Ceza sistemi kurumları çalışma için tatmin edici yerler değildir. Ceza kurumlarında doktor-hasta ilişkisi için gerekli olan güven duyma tehdit altındadır ve birçok psikiyatr için ceza sistemi ortamı çok rahatsız edicidir. Cezaevi ortamında yüksek gerilim bulunduğundan karışıklık çıkmasını önlemek amacıyla gereğinden fazla ilaç tedavisi uygulama eğilimi vardır. Çeşitli zamanlarda ceza kurumlarındaki adli psikiyatri uzmanlarından birçok nedenlerle uygun psikiyatrik tedaviyi kısa sürdürmesi ya da sonlandırması beklenebilir. Aynı zamanda tutuklu veya hükümlüler ısrarcı, hileci ve bazen de uygun olmayan nedenlerle bakım arayışında olabilirler. Panelde bu başlıkların ele alınması ve tartışılması planlanmıştır.

References

1. Bell C.C., Ceza Sisteminde Psikiyatri; Sadock BJ, Sadock VA (Editors):Kaplan & Sadock’s Comprehensive Textbook of Psychiatry (Çeviri Editörleri): Aydın H., Bozkurt A., 8. Baskı, Güneş Kitabevi, Ankara 2007, Cilt 4, 4002-13
2. Soysal H. Adli Psikiyatri, Güncellenmiş Basım. İstanbul: Özgür Yayınları; 2012
3. Uygur N (Ed) (2018) Adli Psikiyatri Uygulama Kılavuzu. Güncellenmiş 3. Baskı, Ankara, Türkiye Psikiyatri Derneği Yayınları.

ETHİCAL AND LEGAL FRAMEWORK FOR HUMAN EXPERİMENTAL TREATMENT RESEARCHES

Eldem Güvercin

The development of medicine and treatment capabilities has been possible by means of human experimental treatment research. Median market time of newly discovered drug is 11,8 years (1) , efficacy and safety tests on many people are required. There are many legal procedures for researches that must be followed for planning and conducting stages. Especially in the World War II , many wild experiments on vulnerable groups condemned the establishment of international standards in terms of legal and ethical frames. The Nuremberg Code, which was published in 1947 to prevent deploitation of human subjects and preserve human rights in experimental research (2). This publication consists of 10 principles and at first paragraph, stated that participation must be voluntary (3) After the following years, more detailed international documents such as The Decleration of Helsinki and The Convention on Human Rights and Biomedicine were published and approved in the domestic law of many countries. In spite of this, many ethical and legal violations occurred.

Turkey has adopted the Decleration of Helsinki and The Convention on Human Rights and Biomedicine in domestic law, and has enacted laws based on these documents. Common features of all human experimental researches include ethics committee approval, informed consent, free will to take part and leave, and protection of the privacy and security of the participants. In this presentation, domestic and international documents on this issue and examples from some experimental human studies with ethical and legal problems will addressed.

References

1. Lexchin J. (2021). Time to market for drugs approved in Canada between 2014 and 2018: an observational study. BMJ open, 11(7), e047557. *https://doi.org/10.1136/bmjopen-2020-047557*
2. Annas GJ, Grodin MA. The Nazi Doctors and the Nuremberg Code. New York: Oxford University Press; 1992.
3. Bernard A Fischer, IV, A Summary of Important Documents in the Field of Research Ethics, Schizophrenia Bulletin, Volume 32, Issue 1, 1 January 2006, Pages 69–80, *https://doi.org/10.1093/schbul/sbj005*

THE NON-MOTOR SYMPTOM CONCEPT AND COGNİTİVE DYSFUNCTİON İN PD

Assoc. Prof. Dr. Gül Yalçın Çakmaklı

Hacettepe University, School of Medicine, Department of Neurology

Abstract:

Parkinson's disease (PD) is a progressive disease, prevalence of which increases with age, to around 1% after the age of 60, and is characterized by motor findings such as tremor, slowness, and stiffness. Motor symptoms are associated with the loss of dopaminergic neurons in the substantia nigra pars compacta (SNpc) in a neurodegenerative process. In recent years, it has been understood that motor symptoms, which are the main component of the disease, actually constitute the tip of the iceberg, and that non-motor symptoms, which have a negative impact on the quality of life at least as much as these symptoms, constitute an important part of the disease process. Non-motor symptoms include cognitive impairments, depression, anhedonia, anxiety, hallucinations, sleep-related and autonomic disorders. There is strong evidence that these symptoms are associated with the progression of alpha-synuclein pathology from the preclinical and premotor stages of the disease from the lower brainstem to the cortex.

Cognitive disorders constitute an important problem starting from the early stages of the disease, and even more than motor disorders in the later stages, since symptomatic treatments do not benefit significantly. PD dementia (PDD) occurs in one third of patients and its incidence increases with age. Older age at disease onset, more severe motor symptoms, longer duration, signs for atypical parkinsonism such as early autonomic dysfunction, symmetric motor involvement, suboptimal response to dopaminergic treatment and confusion and hallucinations with treatment, presence of REM sleep behavior disorder and postural instability and speech disturbance are factors associated with increased risk of dementia. Attention problems, visuospatial and executive dysfunction characterize PDD clinically. Dementia also constitutes an important risk factor for morbidity and mortality.

In this presentation, the concept of non-motor symptoms in PD will be explained with its clinical and pathophysiological aspects, and the course, characteristics and treatment of cognitive deterioration symptoms seen in PD from early to advanced stages will be discussed.

References

1. Schapira AHV, Chaudhuri KR, Jenner P. Non-motor features of Parkinson disease. Nat Rev Neurosci 2017;18: 435–450.
2. O'Callaghan C, Lewis SJG. Cognition in Parkinson's Disease. Rev Neurobiol. 2017; 133:557-583.
3. Hanagasi HA, Tufekcioglu Z, Emre M. Dementia in Parkinson's Disease. J Neurol Sci 2017; 374: 26-31.

PSYHOSİS AND IMPULSE CONTROL DİSORDERS İN PARKİNSON'S DİSEASE

Elçin Özçelik Eroğlu

Hacettepe University School of Medicine, Department of Psychiatry

Parkinson's disease (PD) is a neurodegenerative disease which is characterized by loss of dopaminergic neurons in the substantia nigra pars compacta. Along with motor symptoms, non-motor symptoms are also frequently seen in PD. Psychosis is the one of non-motor symptoms of PD. Psychotic symptoms in PD cause increased mortality and morbidity and have negative effects on quality of life. Psychotics symptoms consist of hallucinations, delusions and minor psychotic phenomena which includes sense of presence, passage hallucinations and illusions seen in PD and they typically occur in the advance stage of PD. The prevalence of Parkinson's disease psychosis (PDP) varies and visual hallucinations are the most prevalent of all. There are several risk factors such as duration of illness, severity of illness, cognitive decline, presence of comorbid psychiatric disorders for development of PDP. Neurobiology of psychotic symptoms is complex and neurodegenerative progressive pathophysiology of PD, antiparkinsonian drugs, visual processing deficits, genetics, sleep disorders may play a role in PDP (Austgen and Marsh 2022). Pimavanserin, clozapine and quetiapine can be used for the treatment of PDP (Isaacson and Citrome 2022).

Impulse control disorders in PD are defined as abnormal repetitive behaviours which include pathological gambling, compulsive buying, binge eating, hypersexuality, dopamin dysregulation syndrome and punding. Dopamine replacement therapy especially dopamine agonist drugs are the main risk factors for ICD and non-pharmacological risk factors such as sociodemographic and genetic risk factors have also been identified (Marques et al. 2018). There is no specific agent approved for the treatment of ICD, a first approach is commonly dose reduction or discountination of the dopamine agonist agents (Faouzi et al 2021).

In this presentation, psychosis and impulse control disorders in Parkinson's disease will be presented. The clinical features of these syndromes, the pathophysiological mechanisms that cause psychotic symptoms and impulse control disorders in PD and treatment approaches will be discussed.

References

Austgen G, Marsh L. 2022. Cognitive dysfunction and neuropsychiatric aspects of Parkinson's disease. Prog Brain Res. 269:59-90.

Faouzi J, Corvol JC, Mariani LL. 2021. Impulse control disorders and related behaviors in Parkinson's disease: risk factors, clinical and genetic aspects, and management.
Curr Opin Neurol. 34:547-555.

Isaacson SH, Citrome L. 2022. Hallucinations and delusions associated with Parkinson's disease psychosis: safety of current treatments and future directions. Expert Opin Drug Saf. 3:1-7

Marques A, Figorilli M, Pereira B, Derost P, Debilly B, Beudin P, Vidal T, Durif F, Fantini ML. 2018. Impulse control disorders in Parkinson's disease patients with RLS: a cross sectional-study. Sleep Med. 48:148-154.

APATHY, ANHEDONIA, DEPRESSION IN PARKINSON'S DISEASE

M. İrem Yıldız
Hacettepe University Faculty of Medicine, Psychiatry Department

Summary:
Non-motor symptoms in Parkinson's Disease represent one of the major challenges faced in the management of disease. Emotional disturbances like depression and anxiety are the non-motor symptoms that are frequently seen in Parkinson's Disease and increase the burden of the patient and caregiver the most. Depression, which is a common mental disorder in Parkinson's Disease is often underdiagnosed and the delays in the diagnose and treatment cause a decrease in quality of life, cognitive functions, and treatment compliance (Lo Buono et al. 2021).

Apathy, another mood symptom of Parkinson's Disease, is described as a lack of motivation that leads to a decrease in goal-directed activity in behavioral, cognitive and affective domains that may result in such diverse states as

indifference, reduced or lack of concern, initiative, and decision making with far reaching consequences for daily living (Ineichen et al. 2021). Half of the patients may develop apathy in the absence of depression and cognitive decline. It may accompany motor symptoms from the onset of the disease, or it may occur at any stage of the course, and is one of the indicators of unfavorable prognosis as it is associated with an increased risk for developing dementia.

Anhedonia is a common mental complaint in patients with Parkinson's disease, defined as a decrease in the capacity for pleasure and associated with worsening of motor symptoms. While it is accepted as an indicator of depression and apathy by some authors, it is also suggested that it is a separate entity and independently of the presence of depression, it can be considered to be a specific mood disorder explained by hypoactivation of the dopamine reward pathway secondary to the degenerative processes observed in PD, particularly in the mesolimbic area Sipos-Lascu et al. 2021).

In this presentation, the diagnosis, differential diagnosis and treatment of depression, apathy and anhedonia symptoms in Parkinson's Disease will be discussed.

References

1. Lo Buono V, Palmeri R, De Salvo S, et al. Anxiety, depression, and quality of life in Parkinson's disease: the implications of multidisciplinary treatment. *Neural Regen Res*. 2021;16(3):587-590.
2. Ineichen C, Baumann-Vogel H. Deconstructing Apathy in Parkinson's Disease: Challenges in Isolating Core Components of Apathy From Depression, Anxiety, and Fatigue. *Front Neurol*. 2021;12:720921.
3. Sipos-Lascu D, Vesa ŞC, Perju-Dumbravă L. Apathy and Anhedonia: Clinical and Neurophysiological Assessment of a Romanian Cohort. *Brain Sci*. 2021;11(6):729.

WHY DOES A PERSON COMMIT SUICIDE?

Uzm. Dr. Lara Utku İnce
Serbest Hekim- Kuşadası

"There is but one truly serious philosophical problem and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental question of philosophy." states Albert Camus in the opening of the philosophical essay The Myth of Sisyphus.(Camus 2013)

According to Camus, people commit suicide "… because they judge life is not worth living" (Camus 2013) He clarifies the attitude of people towards life through the concept of "absurd". Absurd man; this is a person whose value of judgments have been destroyed, whose beliefs have been emptied, who does not understand other's language. As a result, he alienates himself, others and the world with each passing day.(Yaman 2017) Suicide stands as a possibility at the end of this alienation.

Meaning is another important existential concept. It is seen as a "loss of meaning" in cases of suicide. Viktor E. Frankl, who has developed Logotherapy places "Meaning" at the center of theory. Frankl cites one of Nietzsche's famous aphorisms: "He who has a why to live for can bear with almost any how" Frankl considered this "why" as the meaning of life. (Frankl 2009)

Existential frustration arises when we lose our desire to search for the meaning. As long as there is a difference between who we are and who we want to be, we experience existential anxiety. When we don't feel this anxiety, we fall into the existential void with a feeling of boredom, nothingness, and uselessness. Frankl doesn't see existential frustration and existential void as a pathology. (Frankl 2009) He finds them as a kind of invitation to be aware of ourselves. But also the weakness of the connection to reality, and the level of pathology can also lead the person to suicide.

A person begins to feel like an object in this meaninglessness and alienation. As a therapist, we must establish the I-Thou relationship that Buber describes and mediate our patients to feel "alive" again. We can do this by entering the patient's reality as much as they can accept, and "respecting their pain" on the basis of empathy and "accompanying" as much as we can.

References

1. Camus A (2013), Sisifos Söyleni (Çev Tahsin Yücel). İstanbul, Can Sanat Yayınları, s. 21-3.
2. Yaman YA, (2017) Camus: Yaşam ve ölüm felsefesi, Yaşam ve Ölüm Felsefesi, 1. Baskı, Çüçen AK (Ed), Ankara, Sentez Yayıncılık, s. 361-2
3. Frankl VE, (2009) İnsanın Anlam Arayışı, (Çev Selçuk Budak). İstanbul, Okuyan Us Yayınları, s. 111-23

EXİSTENTİAL VİEW ON PHYSİCİAN SUİCİDES

Dr. Fahmin Hagverdiyev
Istanbul University Istanbul Faculty of Medicine
Turkish Psychiatric Association, Existential Psychotherapies Working Unit

Phenomenology is a method that put forward by Husserl, but it found an application area with Heidegger. We can briefly understand phenomenology as the field that studies phenomena. We can understand the phenomenon as showing itself to us as we can perceive it. In this context, Heidegger replaced ''the subject'' with ''da-sein'' and emphasized that we can only examine ''da-sein'' as 'being there' by the phenomenological method.

Since we can only take seriously ''Da-sein''s self-expression with an existential perspective, two sources draw our attention to the existential view of physician suicides. One is that people who have committed suicide wrote themselves before their suicide. Another is what people ,who have suicidal plans, share about suicidal thoughts.

So what happens when a doctor commits suicide?

In the book titled "Phisicians suicide letters", written by Pamela Wible, the letters written to her by e-mails by the physicians who have intensified suicidal thoughts(1) . This letters are important because they are first-hand statements who have suicidal thoughts.

Our aim as physicians is to keep alive. The first great paradox appears here: the suicide of the one who tries to keep alive: Suicide, not death. So where is the difference? The difference is between "choose death" and "die". Let us remember the fact that it is death that affirms life . Perception of life as a phenomenon is only possible if the possibility of death is on the agenda. In this context, suicide should only be kept in our "side pocket" as an "option". The purpose of the suicide option being there is to make all other options meaningful. Choice, on the other hand, is the most concrete form of the freedom that existentialism "condemns" man.

We can summarize existentialism with Sartre's proposition "Existence precedes essence". Sartre emphasizes that human beings as conscious beings are "etre-pour-soi". On the other hand, if you take the chance to choose from 'Da-sein's hand, it turns into a a " etre-en-soi" . (2)

While Camus was drawing the line between supernatural rebellion and historical rebellion from killing, he , who did not give importance to killing for any reason, formulated the incompatibility and absurdity of man with nature as rebelling and maintaining it as a consciousness against nature. For this reason, physicians, as those who give the most concrete form of this rebellion, are primarily concerned with death philosophically. The suicide of the physician is the most embodied form of the "rebellious man" who renounces rebellion, that is, this type of suicide undeniably reveals the great defeat of man. This raises an ethical problem with a Sartrean point of view.

The thought of "man is freedom", emphazed by Sartre, means "if there is no freedom, there is no existence". This is exactly what Sartre talked about in his work "Huis Clos": Interruption of freedom by another. Among unfree individuals, I am not free either, if I am not free, it means "I do not exist", only "I exist".

So what can prevent a physician from committing suicide?

Anything that can prevent a person from committing suicide!!! Not more. Because, first of all, we are the ones who build our essences on our existence. Being a physician only requires the construction of the essence "as a physician" too. As Camus addresses us through Dr. Rieux in his novel "The Plague" : "When one becomes a physician, one gets an idea of pain and a little more imagination".

But the most we can be is still "The Human"

1. "Physician suicide letters'', 2016, Pamela Wible.
2. "Existentialism'', 1985, Jean-Paul Sartre, int. A.Kadir Bezirci.
3. "The Rebel'' 1951, Albert Camus

WHY DO PSYCHIATRISTS COMMIT SUICIDE? AN EXISTENTIAL APPROACH TO THE SUICIDE OF PSYCHIATRISTS

Onur Yılmaz
Doğuş Üniversitesi Psikoloji Bölümü

All over the world, psychiatrists are placed to second position in frequency of commited suicides among medical doctors (the first to be anaesthetists).

Additional risk factors of psychiatrists may be, being overloaded with bureaucratic processes; being pointed as targets to patients and families/relatives of patients; underestimation from other medical doctors, witnessing extremely hurting experiences which are hidden otherwise; being extremely emphatic; slurring over or postponing the need for vacation and embarrasment from psychiatric symptoms. A further critical risk factor is that psychiatrists have a tendency to be blinded to their psychiatric symptoms. Moreover, after facing malicious aspects of humankind, psychiatrists may be so distressed that they may unconsciously choose to avoid from talking about the malignant side in themselves.

Sigmund Freud died bey suicide after being diagnosed with jaw cancer, probably the consequence of his intense morphine usage which started after his effort to help one of his colleagues beating morphine addiction. Viktor Frankl, the founder and theorist of existential analysis and logotherapy, was closely interested in suicides and was responsible from the suicide unit during his residency. He described the noetic dimension of humans (1), which was further formalized as ''Umwelt (spiritual world)'' in four-dimensional understanding of human experiences provided by Emmy Van Deurzen(2). Uberwelt is also subjected to the polar understanding of existential dimensions. In Uberwelt, the existentially healthy state is experiencing meaninglessness as well as meaning; being ordinary as well as self transcendence; and feeling as a bad person as well as a good one from in the course of time. From this point of view, the classical ethical understanding of being a medical doctor, particularly a psychiatrist, seems to project existentially unhealthy demands on doctors at least to some extent.

The founder of British Existential Analysis, Ronald David Laing, had a specific interest on schizoid and psychotic people(3). According to his approach, psychosis represents a way of existence which does not remarkably make room for the self. Moreover, psychosis is a hopeless and lonesome frame. Indeed, this counts for all the individual dead-ends. Modern society has high standards of functionality which any person will eventually fail to meet. When a psychiatrist does not let her/himself any place for this natural insufficiency (particularly with the effect of classical understanding of being a medical doctor), the course of events will more likely tend to reach to a suicidal way.

Although not known as an existential philosopher, Hegel, in a manner, addresses wisdom as superior to behave as a scientist. Eventually, psychiatrists may benefit from placing themselves in a more healthier existence in order to decrease the risk of suicide.

References

1. Landau, I. (2019). Viktor Frankl on all people's freedom to find their lives meaningful. Human Affairs, 29(4), 379-386.
2. Van Deurzen, E., & Adams, M. (2016). Skills in existential counselling & psychotherapy. Sage.
3. Laing, R. D., & Esterson, A. (2016). Sanity, madness and the family. Routledge.

GENERAL FRAMEWORK AND MEASUREMENT METHODS

İmran Gökçen Yılmaz Karaman

Eskişehir Osmangazi Üniversitesi Tıp Fakültesi Psikiyatri Anabilim Dalı

Gender-based violence against women is a widespread public health problem. In health research, exposure to violence is considered a chronic stress factor and a psychosocial determinant of health. There are methodological challenges in this multidisciplinary research area. Some of these are that the studies are conducted with women who apply to social services or medical treatment, the differences in which behaviors are considered violence, and the lack of measurement tools that will yield consistent results across cultures. In addition, the attitude of the interviewers who made the measurement or the environment in which the self-report questionnaires were filled may cause changes in the rates of violence reporting. Researchers should ensure that adequate precautions are taken for the safety of the participants during this time. The “Nordic paradox,” the prevalence of violence against women in countries with better gender equality, is another aspect of methodological problems in violence against women research. In societies where inequality of power is evident, women have to behave according to gender stereotypes that can be misinterpreted as the absence of violence if not carefully evaluated. In addition, with the increase in masculine role stress and the more significant presence of women in the public space in developed countries, the incidence of violence against women may be higher. Cultural and psychological factors come into play in response rates. Due to avoidance of traumatic experiences, the person may refuse interviews or volunteer if there is motivation to talk about it. Studies have shown that reported violence rates decrease as survey response rates increase.

When planning research on violence against women in the field of health, it should be clarified which type(s) of violence against women will be investigated and its relationship with which mental disorder or between which diagnoses will be evaluated. Without an appropriate design, the aim of the research may be missed even with scales with proven validity and reliability. Qualitative studies may serve the purpose better than quantitative measurements in some cases.

While planning the research, precautions should be taken to ensure the safety of both the interviewees and the participants. With the COVID-19 pandemic, research conducted by collecting data with an online survey has brought up security problems in the online field.

References

1. Ellsberg M, and Heise L. Researching Violence Against Women: A Practical Guide for Researchers and Activists. Washington DC, United States: World Health Organization, PATH; 2005.
2. Humbert AL, Strid S, Hearn J, Balkmar D. Undoing the ‘Nordic Paradox’: Factors affecting rates of disclosed violence against women across the EU. PLoS One. 2021;16(5):e0249693. Published 2021 May 5. doi:10.1371/journal.pone.0249693

MEASUREMENT FORMAT PROBLEMS

Çiğdem Çolak Kalaycı
Serbest Hekim

Obtaining different results in terms of both prevalence and findings in violence against women researches is not only due to the fact that the studies are conducted in different places, but also because different methods are used in the studies. There are many factors that affect the results such as the environment in which the history of violence was questioned, the story was obtained through a questionnaire or a clinical interview, the person was alone or not in the interview, the education/attitude of the interviewer, etc. Also different forms of violence against women pose different challenges for data collection. Questionnaires and clinical interviews are the most commonly used methods to question violence.

Although it is possible to reach a larger number of people quickly with the questionnaire method, it is possible to reach more information in the clinical interview than questionnaire and also to obtain data from the non-verbal communication ways of the person. Many studies have revealed that people tend to hide violence when answering surveys. On the other hand large scale national surveys that are conducted only in the dominant national language tend to omit certain population groups, such as immigrant/refugee women, or women in detention.

There are also many different methods of questioning violence in the clinical interview such as structured, semi structured or unstructured. These interview methods have their own advantages and disadvantages.

Considering all these situations it is important not to neglect questioning violence against women in daily clinical practice.

In this presentation, it will be discussed how the interview environment and content should be and which research methods should be preferred in research on violence against women.

References

1. Doğanavşargil Ö, Vahip I, (2007) Fiziksel Eş Şiddetini Belirlemede Klinik Görüşme Yöntemi. Klinik Psikiyatri, 10:125-136
2. Watts C, Zimmerman C (2002) Violence against women: Global scope and magnitude. The Lancet, 359: 1232-1237.
3. Researching Violence Against Women - A Practical Guide for Researchers and Activists(2005), World Health Organisation and Program for Appropriate Technology in Health - Chapter Nine, Tools for Collecting Qualitative Data, 123-153.

CONCEPTS OF TRANSFERENCE AND COUNTERTRANSFERENCE

Çağla Pınar Sevinç Yalçın

Transference was known from the very beginning of psychoanalysis. Transference reactions occur in all patients undertaking psychotherapy. Psychoanalysis is distinguished from all other therapies by the way it promotes the development of the transference reactions and how it attempts thoroughly to analyse transference phenomena. Transference is the patient's conscious and unconscious experience of the analyst in the psychoanalytic situation as it is shaped by the patient's internalized early life experiences. Also according to Greenson transference refers a special kind of relationship toward a person and it is a unique type of object relationship. The main characteristic is the experience of feeling to a person which do not suit that person and which actually apply to another. Basically, a person in the present is reacted to as though he were a person in the past (Greenson, 1973). According to Freud (1915) transference is a repetition, a new edition of and old object relationship. The patient's transference can be positive or negative. Freud viewed positive transference as a critical motive for the patient's cooperation. It can be understood as both a resistance (the patient repeats rather than remembers) and hence, an complication to the analysis; and as of an essential value to the analysis. Since the process involved is largely unconscious, the patient does not perceive the various sources of transference attitudes, fantasies, and feelings (such as love, hate, and anger). Transference may consist of any components of an object relationship; it may be experienced as feelings, drives and wishes, fears, phantasies, attitudes, and ideas or defences against them. The people who are the original sources of transference reactions are meaningful and significant people of early childhood (Freud, 1912; 1936). Transference occurs in analysis and outside of analysis, in neurotics, psychotics, and in healthy people. Transference is manifested not only in the patient's associations and subjective experience, but also in his unconscious attempts to enact conflictual, wished-for interactions with the analyst (Sandler, 1976a) Unlike the traditional views of a 'blank screen' analyst, in contemporary views the patient's transference reactions are understood as, at least to some degree, elicited by cues emitted by the analyst. In this respect countertransference can be defined the whole of the analyst's unconscious reactions to the individual analysand–especially to the analysand's own transference (Laplanche & Pontalis, 1973). Since then, discussions of countertransference have continued to elaborate mainly on two basic views. The first view focuses on countertransference as an important source of information about the patient. The second view focuses on the analyst's own intrapsychic life. From another point of view, Ogden (1994) and others have viewed the analytic dyad from an intersubjective perspective in which the separate subjectivities of the patient's transference and analyst's countertransference exist in dialectic tension with a new, mutually created, intersubjective experience that Ogden called the "analytic third." The analyst's reflection on this joint creation is central to his understanding of the patient's subjective experience.

References

1. Freud, Sigmund (1912) 'Recommendations to physicians practising psychoanalysis'.Standard Edition12, pp. 109-20.
2. Freud, S. (1914). Observations on transference love.Standard Edition, 12:157-171.
3. Freud, Sigmund (1915) 'Remembering, repeating and working through'.Standard Edition14 pp. 121-45.
4. Greenson, Ralph R, (1973) "Transference" from Greenson, Ralph, R, The Technique and practice of psychoanalysis vol 1. Pp.151-190 , London: Hogarth Press
5. Laplanche, J. and Pontalis, J. B. (1973). The Language of Psycho-Analysis.
6. Ogden, T. H. (1994). The analytic third: Working with intersubjective clinical facts. The International Journal of Psychoanalysis, 75(1)
7. Sandler, J. (1976a). Dreams, unconscious fantasies and "identity of perception." Int. Rev. Psychoanal., 3:33–42.

THE ROLE OF PSYCHIATRISTS AND PROFESSIONAL ASSOCIATIONS IN THE STRUGGLE AGAINST GENDER AND SEXUAL IDENTITY RELATED DISCRIMINATION AND VIOLENCE

Koray Başar

Department of Psychiatry, Faculty of Medicine, Hacettepe University, Ankara, Turkey

Health disparities associated with sexual and gender identity present as a public mental health issue in almost all countries. The research provides consistent evidence on the "Minority Stress Model" as a valid framework in the emergence of mental and physical health issues and disorders in the groups with sexual and gender identities facing discrimination and violence based on their identity. In various cultures, sexual orientation and gender identity-related discrimination, both anticipated, perceived, and enacted have been shown to be directly or indirectly associated with morbidity and mortality. Throughout its history, psychiatry has contributed to the discrimination these groups experience, in some cases, it provided the means to oppression, and sometimes employed so-called "treatments" which are currently considered inhumane and unethical.

Unfortunately, the depathologization of these identities in the last decades will not be sufficient to decrease the disparity. Since healthcare professionals and their applications are not the sole sources of discrimination. Yet, psychiatrists and their professional organizations have an ethical obligation to eradicate unethical practices. Moreover, they have to find ways to make their service provision as inclusive as possible. These steps are not only related to the patient-doctor relationship; they also involve recognition of the diversity with respect to gender and sexual identity among the professionals. This diversity should find its reflection in almost all activities of the professional associations. Professional organizations should have specialized units that promote the representation of this diversity and struggle the discriminatory discourse and actions within the profession.

In addition to the clinical and professional relationships, the psychiatrist and the professional organizations have the power, resources, and responsibility for public education. Psychiatrists, at both individual and organizational levels, should stand explicitly and firmly against discrimination and violence, and by the rights of all sexual and gender identity minorities. Furthermore, they should encourage the means to achieve social support through their inclusion in all public domains, without the threat of being discriminated against. This struggle against discrimination and violence, way beyond the walls of the clinic, is still a professional responsibility of the mental health professional.

TO BE: FROM DREAM TO PLAY

F. Bahar Atak Akkuş

Department of Psychiatry, Kars Harakani State Hospital

The body has always been seen as a boundary that one must cross, and the notion of immortal-super-human has become a point that technological utopia is intended to reach. In recent years, the concepts of 'being' and 'existence' have become even more complex, together with digital technology, the body, space, time, and boundaries are erased. It's like a person leaves this universe and migrates to this uncanny universe called 'metaverse'. How does a postmodern individual experience this process of migration, and what position is he/she in this universe? Is the virtual situation perpetually an alternative to reality or a secure copy? And will this virtual universe make immortality possible? In this session, we will attempt to ask questions about the presence and experience of postmodern people in the progress of development and change.

Freud explains that in Civilization and Its Discontents, a civilized man traded some of his own happiness potential for a piece of security. In that sense, there is a constant tension in this conflict between 'the pleasure principle' and 'the reality principle'. If we consider the virtual universe that way, it could be a substitution of the pleasures to reduce the tension. Fantasies and dreams are fundamental to psychic survival and development1. According to Winnicott, child gaming is not just about manipulating objects, it's about translating internal life2. In fact, it's related to putting on fantasies and dreams forming the internal life3. Cyberspace, virtual reality, and metaverse could be places where fantasies and dreams locate. Another crucial question at this point is how and in which theory the real concept is addressed3. In the Lacanian sense, the Real is not the outside world that surrounds us, in that it is positioned in a real psyche structure and outside the language. The Real is never known, yet only it is contacted through dreams or fantasies. In that regard, if virtual reality is a substitution for fantasies, could it be virtual reality or real virtuality?

Another question might be asked as to the conception of power and subject. Michel Foucault states that postmodernism involves an uprising against modernism, which tries to discipline individuals rather than liberate them4. Is it possible that the postmodern man, who destroyed the borders to be free, could be liberated by technology? Or is the new world with the Metaverse no different than Panopticon?

In a nutshell, we will evaluate several views from psychoanalysis, philosophy, and sociology via the concept of "to be". Our aim is not to determine a certain response, such as modern thinking, yet rather to the question of postmodern irregularities and ambivalence in terms of the concept of "to be" concerning the Metaverse.

References

1. Freud, S. (2005) Civilization and Its Discontents, Edited by: Strachey, J. New York: W. W. Norton.
2. Winnicott, D. W. (1971a.) Playing and Reality. London: Routledge
3. Lemma, A. (2017). The digital age on the couch: Psychoanalytic practice and new media. Routledge.
4. Foucault, Michel. 1979 Discipline and Punish, New York: Vintage Books

TO HAVE: FROM SWALLOWİNG TO PROPERTY

Çilem Kızılpınar
Sanlıurfa Education and Training Hospital

The human mind modifies internal and external realities with a personalized filter (1). Therefore, it will be very difficult to predict the effects of emerging and new technologies on the human mind. Here, we primarily aimed to discuss the impact of developing technology on the human psyche, and then to talk about the future transformation of an individual's process of organizing an identity through 'to have', considering the social and technological developments from past to present. In summary, we will evaluate the effects of emerging technology on human psychology from a psychoanalytic perspective, in the context of 'to have'.

Considering the history of humanity, we can say that humans are always inclined to create things that are not real but seem almost real. Stories, novels, and even myths are mental outputs that are the result of human behavior to create another world. With the development of technology, people create new spaces for themselves with virtual universes. Although terms such as the metaverse and virtual reality have entered our lives in recent years, we can say that they are not so far from psychoanalysis, considering that these are related to the beyond of this world and modified the reality. Because the 'harbors' in which one took refuge in order to avoid anxiety have always been the subject of psychoanalysis. Steiner (2003) reported that the difficult-to-treat patients build 'psychic retreats' for themselves to avoid the anxiety caused by paranoid-schizoid positions or the depressive positions. Consequently, they take refuge from the real difficulties of the world (2). Winnicott (1974) similarly stated that in order to avoid the fear of breakdown, one constructs a psychotic inner reality instead of the real external reality (3).

In the beginning, the baby has an integrated structure with the mOther. When the baby begins to form a unit self, who realizes the lack and turns to objects. Human knows only the lack but does not know what is lacking, since the drive has no specified object. Others point out what or who it will be and then human turns to it (4). In consumer societies, Objects are status symbols and provoke desire, rather than responding to a specific need or problem (5). People define his/her self through these objects and perpetuate their position in society. The ways of having the other have varied in different societies and at different times. In anthropophagi, people fantasize that by eating the other, their powers are passed on to them and these traits cannot be taken from them. With the development of the property, people started to define their identities with the lands, houses, cars, and works of art they own. With the development of technology cryptocurrencies, virtual currencies, and Nun Fungible Tokens (NFT) have become objects of desire. Will the metaverses bring people greed and loneliness by pointing out new things that they will feel they have to 'have'? Or will it be a safe harbor for, contributing to his relationship with the other and even his 'being'?

References

1. Lemma, A. (2017). The digital age on the couch: Psychoanalytic practice and new media. Routledge.
2. Steiner, J. (2003). Psychic retreats: Pathological organizations in psychotic, neurotic, and borderline patients. Routledge.
3. Winnicott, D. W. (1974). Fear of breakdown. International review of psycho-analysis, 1, 103-107.
4. González-Campo, C. H., García Solarte, M., & Murillo Vargas, G. (2013). Avatar (A'): contrasting Lacan's theory and 3D virtual worlds. A case study in second life. Psicología desde el Caribe, 30(2), 309-324.
5. Fromm, E. (1976). To have or to be? Newyork: Harper&Row

BE-HAVE: TOTALLY IN DOUBT

Ayşegül Sütçü
Serbest Psikiyatr

With the emergence of new technology, numerous terms began to enter our lives. For instance, virtual reality generally refers to the generation by the computer software of an image or experience of environments that appear real to the senses, in that an avatar is an interactive social representation of its user that can be controlled by the user and mediates interactions online. Thus, it may be simulated as a "portrait" of us1. The individual might get in touch with others through in the virtual world with his/her avatar or uses it as an unoccupied space to the carry out omnipotent fantasies of unbridled freedom. Here, we aimed to produce new questions in your mind about the impacts of developing technology on the human psyche and evaluate the effects of emerging technology on human psychology from a psychoanalytic and meta psychological perspective, in the context of 'to be', 'to have', and 'behave'.

Virtual terms typically stand in opposition to the notion of 'real'2. But in our psychoanalytical approach, we are accustomed to the virtual nature itself of the real. Also, we can say that virtuality is not so far from psychoanalysis. So, if the virtual and the real are so close to each other, why should we separate from each other? Then maybe this augmented interest in virtual worlds is a result of human curiosity for reality?

While we are in cyberspace or another virtual universe, we feel having all the control. The fact that our requests are handled with a single click gives us this feeling. So, do we actually behave our own preferences in there, or do different dynamics direct our behaviors?

How will the functions of the body change in the real and virtual universe with technological developments? Does this contribute to a split between body and self? Several questions arise when we think about the lines of the virtual as an alternative to reality3, rather, as an increase in what is now called virtual. Our aim here is not to answer questions, but to ask new questions to convey our complete doubts.

References

1. Meadows , M . (2008) *I, Avatar: The Culture and Consequences of Having a Second* Life . San Francisco, CA : New Riders Press .
2. Lemma, A., Caparrotta, L. (Eds.). (2014). *Psychoanalysis in the technoculture era* (p. 134). London: Routledge
3. Lemma, A. (2015) Psychoanalysis ,n times of technoculture: Some reflections on the fate of the body in virtual space. *International Journal of Psychoanalysis,* 96(3(, 569-582.

BE-HAVE: TOTALLY IN DOUBT

Ayşegül Sütçü
Serbest Psikiyatr

With the emergence of new technology, numerous terms began to enter our lives. For instance, virtual reality generally refers to the generation by the computer software of an image or experience of environments that appear real to the senses, in that an avatar is an interactive social representation of its user that can be controlled by the user and mediates interactions online. Thus, it may be simulated as a “portrait” of us1. The individual might get in touch with others through in the virtual world with his/her avatar or uses it as an unoccupied space to the carry out omnipotent fantasies of unbridled freedom. Here, we aimed to produce new questions in your mind about the impacts of developing technology on the human psyche and evaluate the effects of emerging technology on human psychology from a psychoanalytic and meta psychological perspective, in the context of ‘to be’, ‘to have’, and ‘behave’.

Virtual terms typically stand in opposition to the notion of ‘real’2. But in our psychoanalytical approach, we are accustomed to the virtual nature itself of the real. Also, we can say that virtuality is not so far from psychoanalysis. So, if the virtual and the real are so close to each other, why should we separate from each other? Then maybe this augmented interest in virtual worlds is a result of human curiosity for reality?

While we are in cyberspace or another virtual universe, we feel having all the control. The fact that our requests are handled with a single click gives us this feeling. So, do we actually behave our own preferences in there, or do different dynamics direct our behaviors?

How will the functions of the body change in the real and virtual universe with technological developments? Does this contribute to a split between body and self? Several questions arise when we think about the lines of the virtual as an alternative to reality3, rather, as an increase in what is now called virtual. Our aim here is not to answer questions, but to ask new questions to convey our complete doubts.

References

1. Meadows , M . (2008) *I, Avatar: The Culture and Consequences of Having a Second* Life . San Francisco, CA : New Riders Press .
2. Lemma, A., Caparrotta, L. (Eds.). (2014). *Psychoanalysis in the technoculture era* (p. 134). London: Routledge
3. Lemma, A. (2015) Psychoanalysis ,n times of technoculture: Some reflections on the fate of the body in virtual space. *International Journal of Psychoanalysis,* 96(3(, 569-582.

A CONCEPTUAL PERSPECTIVE ON TREATMENT RESISTANCE IN ADHD

Assoc. Prof. Esin Erdoğan

University of Health Sciences, Izmir Bozyaka Training and Reseach Hospital, Department of Pscyhiatry, Izmir, Turkey

The lifetime diagnosis of ADHD and the ability of individuals to receive appropriate treatment are associated with a wide range of life impairments that require a comprehensive and accurate diagnostic assessment. It is important for professionals working in this field to be able to monitor treatment response to determine whether appropriate interventions are needed to achieve optimal therapeutic outcomes or whether referrals for additional treatments and support are necessary. Structured interviews and inventories/scales are major components of a comprehensive diagnostic assessment as well as a means for tracking treatment response in either clinical setting or research. For example, pharmacotherapy for adult ADHD often targets symptom reduction, psychosocial treatment targets functional changes in behavioral terms, such as reduced procrastination or increased use of time management skills, and both struggle for the overall reduction in life impairments and improved wellbeing and quality of life. Just as functional status measures can be used to track pharmacotherapy response, ADHD symptom measures can be used to monitor psychosocial treatment response.

Around 30% of individuals with ADHD had poor responses to psychostimulants. Studies revealed that individuals with ADHD having poor intelligence quotient, higher disease severity, and a family history of a psychiatric disorder showed a poor response to methylphenidate (MPH). Further, higher anxiety levels, as well as co-occurring personality, substance use, alongside anxiety disorders are related to suboptimal MPH responses in individuals with ADHD.

Structural and functional neuroimaging studies have revealed significant associations between various regions of the brain and response to treatment in individuals with ADHD. At this point of view investigating an individual's neurobiological variations may provide better explanations and have translational potentials to identify those poor responders before initiate of methylphenidate prescription.

Longstanding syptoms of ADHD creates pervasive and severe difficulties in life functioning and it takes time to get desired improvements such as remission and/or optimal functioning. Because most adult ADHD symptom ratings and ADHD inventories provide normative data, these norms can also be considered a good measure of treatment response. The conventional threshold for "clinical elevation" on such measures is typically 1.5 or 2.0 standard deviations above the mean, or at the 93rd or 98th percentile, respectively. Follow-up scores falling within 1.0 standard deviation of the normal mean is a threshold for normalization. Calculating percentage markers of improvements, such as 30% reduction in symptoms is a other metric often used in clinical trials. In this case, considering the above-mentioned issues, it becomes important to include detailed diagnostic, follow-up and neurobiological evaluations in the treatment strategies of individuals in order to talk about treatment resistance in ADHD.

COMORBIDITIES OVERSHADOWING THE DIAGNOSIS IN ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD); RECOGNIZING ADHD IN COMORBIDITY

Assist. Prof. Ece Büyüksandalyacı Tunç

Maltepe University Faculty of Medicine, Department of Psychiatry

Attention deficit and hyperactivity disorder (ADHD) is one of the most common psychiatric disorders in childhood, characterized by inattention, hyperactivity, and impulsivity. Studies show that 60% to 80% of children diagnosed with ADHD continue to have symptoms in adulthood (1). Successful management of adult ADHD includes awareness and recognition of conditions among adults that may hinder the diagnosis and treatment of ADHD. Some of these disabling conditions are high comorbidity, not being diagnosed in childhood, individuals having compensatory mechanisms in adult ADHD and not seeking treatment, and patients' negative opinions about stimulant drugs for ADHD treatment. Given these difficulties and the lack of detailed diagnostic guidelines, prevalence estimates are often inaccurate and contribute to the underdiagnosis of adult ADHD (2).

It is estimated that 5% of the adult population is affected by ADHD. However, less than a third of these adults have been diagnosed with ADHD, probably because of the wide barriers to correct diagnosis. ADHD is often associated with comorbid psychiatric disorders that complicate diagnosis and treatment in the adult population. ADHD has been associated with co-occurring depression, anxiety disorders, bipolar disorder, substance use disorder, obesity, and personality disorders in many studies. The high prevalence of comorbid conditions is estimated at 15% to 75%. The more severe the ADHD, the more likely the individual will experience comorbidities. Approximately 50% to 87% of individuals with ADHD have at least one other comorbid disorder. About 33% have two or more other comorbid disorders. In addition, childhood traumas have recently been associated with childhood ADHD. This situation also increases the possibility of adult ADHD (3).

On the other hand, many-core ADHD symptoms may be nonspecific symptoms of other psychiatric disorders. This poses an obstacle to the correct recognition and treatment of adult ADHD. Undiagnosed ADHD in childhood refers to psychiatry in adulthood due to comorbid conditions accompanying the diagnosis. Comorbid conditions obscure ADHD symptoms, making it difficult to make a clinical diagnosis (4). In these individuals, first of all, making the correct diagnosis is the basis of effective treatment. Comorbidity affects the diagnosis of ADHD and influences treatment pathways, treatment persistence, treatment response, insight, self-regulation, and participation in treatment. Therefore, clinicians need to be aware of the comorbid disorders associated with ADHD. This presentation aims to inform about the recognition of ADHD in comorbid conditions.

References

1. Matthies, S., Philipsen, A. Comorbidity of Personality Disorders and Adult Attention Deficit Hyperactivity Disorder (ADHD)—Review of Recent Findings. Curr Psychiatry Rep 2016;18 (33).
2. Katzman, M.A., Bilkey, T.S., Chokka, P.R. et al. Adult ADHD and comorbid disorders: clinical implications of a dimensional approach. BMC Psychiatry 2017;17 (302).
3. Piñeiro-Dieguez B, Balanzá-Martínez V, García-García P, Soler-López B. Psychiatric Comorbidity at the Time of Diagnosis in Adults With ADHD: The CAT Study. Journal of Attention Disorders. 2016;20(12):1066-1075.
4. Mats Fredriksen, Alv A. Dahl, Egil W. Martinsen, Ole Klungsøyr, Jan Haavik, Dawn E. Peleikis. Effectiveness of one-year pharmacological treatment of adult attention-deficit/hyperactivity disorder (ADHD): An open-label prospective study of time in treatment, dose, side-effects and comorbidity. European Neuropsychopharmacology. 2014;24(12): 1873-1884

PSYCHOANALYTIC COUPLE THERAPY IN 10 QUESTIONS

Y. Özay Özdemir[1], Nuray Türksoy[2]

[1]Psychiatrist, psychoanalyst. Member of International Psychoanalytic Association (IPA) and Psike İstanbul. Associate professor at the Department of University of Health Sciences, Istanbul Erenkoy Psychiatric and Neurological Disorders.

[2]Professor of psychiatry and psychoanalyst. Member of International Psychoanalytic Association (IPA) and Psike İstanbul. Private practice, Istanbul.

Abstract

Couple psychoanalysis focuses on unconscious processes of the couple's relationships. It examines each partner's state of mind regarding the other, their interactions as a couple, and how they relate to significant people in their social circle. Psychoanalytic Couple Therapy (PCT) is "the process created by three interacting variables with the purpose of achieving change": a couple that seeks help and the problems presented by the partners, the therapist, and the setting within which couple and therapist meet.

The therapist is the 'third party' for the couple and creates another triangle in the relational fabric of their lives. As an invited guest to the couple's special event, the therapist has unique opportunities to contribute to knowledge and understanding of unconscious processes by encouraging inquiry and reflection on the emotional experiences of being a couple. As a third party, the therapist is faced with challenging oedipal dilemmas in their work. To help them address the intimacy, separation, and sexuality issues that are typical of being a couple, the therapist must be able to tolerate the anxiety associated with "intruding" into the private lives of others. The experience of a relationship where tension can arise but can be resolved provides a new oedipal experience where one can learn from others, feel supported by the environment.

When PCT and individual therapy are applied simultaneously, it can offer therapists a unique opportunity to encounter the clinical awareness of another therapist. The tension from different perspectives can be creative and provide new perceptions about the patients and the work.

In this presentation, issues such as the clinical features of PCT, simultaneous couple and individual therapy, and the application of PCT during the pandemic will be discussed with clinical material.

References

1. Burch B ve Jenkins C. (1999) The Interactive Potential between Individual Therapy and Couple Therapy An Intersubjective Paradigm. Contemp. Psychoanal. (35) (2): 229-252.
2. Scharff DE, Scharff JS. (2014) Psychoanalytic couple therapy: Foundations of theory and practice. London, Karnac Books.
3. Clulow C. (2011) Couple psychoanalysis and couple therapy: Context and challenge. Couple and Family Psychoanal 1.1: 1-19.

BEHAVIORAL APPROACH TO RUMINATION

M. Hakan Türkçapar
Social Sciences University of Ankara

Rumination is an important trans-diagnostic mechanism found in many psychological disorders, especially depression, obsessive-compulsive disorder and generalized anxiety disorder. Depressed, obsessive and anxious individuals often think about life's difficulties, painful aspects, possible mistakes and ruminate about the symptoms of depression, their doubts and do not solve problems. Rumination often leads to withdrawal, inactivity, and eventually more rumination.

Classical behaviorism considers only the observable, excluding mental processes. Since rumination is basically seen as a mental process, classical behaviorism does not have a specific intervention towards rumination. The modern behavioral theory, on the other hand, describes cognitive processes as a kind of behavior. Modern behavioral theory approaches rumination as a behavior and deals with its function rather than its content. Rumination functions more like escape or avoidance.

Behavioral approach sees thought as a kind of implicit behavior (inner speech, verbal behavior) and deals with its function rather than its content. When dealing with individuals who have a ruminative process, he says that the person should first start with the question of what do I think for instead of what I think.

The ruminative process reduces willingness, problem solving, motivation, and increases depression, anxiety, and doubts. The behavioral approach begins by examining the emotional, mental, behavioral and environmental consequences of rumination. The first step of behavioral interventions aimed at gaining control over the ruminative process begins with increasing awareness of this process, namely rumination. After that, the person is asked to continue for a certain period of time as soon as he or she realizes this process and then to examine that process in terms of its effects.

The last step is to finish this process by performing a certain action or behavior. In other words, the person sees rumination as a kind of sign to take action. What the person will do is to take a step towards his current life or problems.

In summary, the behavioral approach is to 1. An awareness to change this, and 2) to see that this ruminative activity is not beneficial, and finally, to engage in activities that may be more beneficial for the person himself or his environment.

WHY DO WE LIKE RUMINATION?

Ayşegül Kart

Cognitive Attentional Syndrome (CAS) can be defined as a repetitive and brooding focused on self-related topics that is difficult to control. Rumination is a core feature of the CAS in depression. It can be defined as a difficulty to control repetitive thoughts especially linked with depression. In the Metacognitive Model of Depression, there are positive metacognitive beliefs that are responsible of sustained brooding on the meaning and causes of symptoms. It is important to find and modify these positive beliefs becouse they underlie motivation to engage rumination. These positive metacognitive beliefs can be 'ruminating helps me cope', 'If I analyze why I feel this way, I'll find answers', 'ruminating helps me understand my depression' and 'ruminating helps me solve problems'. In this presentation I will present a case of depression and his metacognitive formulation; his triggers, his rumination episodes, his negative and especially positive metacognive beliefs and other CAS domains. Also I will mention about evolutionary approaches to depression and rumination which are controversial. According to the analytical rumination hypothesis rumination and depressive symptoms provide solutions to complex social problems. Andrews and Thomson structure this hypothesis under the four following factors: (1) complex problems trigger depressed affect; (2) depression coordinates changes in body systems that promote sustained analysis of the triggering problem; (3) depressive rumination helps people solve the triggering problem; and (4) depression reduces performance on laboratory tasks because depressive rumination takes up limited processing resources. The major difference between Metacognitive Therapy and analytical rumination hypothesis is in how they consider rumination. Although the analytical rumination hypothesis claims that it is difficult to stop ruminating, metacognitive therapy considers this a false-negative metacognition. Metacognitive therapy has been found to be an effective treatment for major depressive disorder and it is theoretically based on that depressive rumination is maladaptive. I'll also mention about cultural factors that can be effective on rumination and metacognitive beliefs.

THE PARTING OF THE WAYS: WHAT IS GRIEF? HOW SHOULD THE GRIEF INTERVENTION BE?

Dr. Diğdem Göverti

Loss, the loss of someone or something important to a person, is a universal yet multifaceted experience that elicits various expressions of grief and mourning. Grief encompasses a person's psychological, biological, emotional, sociological and/or spiritual response to loss. Grief can be defined as actions arising from the manifestation of one's grief (1). The definition of 'normal' bereavement is a rather contradictory expression used in the face of the indescribable pain experienced by the person who has lost. However, it can be distinguished whether a specific grief response remains within normal limits, depending on the length of the grief symptoms and the extent to which it affects the person's life (2). In the uncomplicated grief process, which progresses from denial to acceptance, if people cannot resolve their feelings and cannot complete the grief stages and return to normal life, grief counseling helps people achieve more successful results (3).

There are certain 'stages of mourning' that a person must go through in order to return to a state of balance and complete the grieving process when he or she experiences any loss. It can be said that the grieving process or adapting to the loss requires four basic stages. These; Accepting the reality of loss is working through the pain of grief, adjusting to an environment where the lost person is absent, and moving on with life by emotionally relocating the deceased to a new place. In the acute phase, emotions such as sadness, anger, guilt and self-reproach, anxiety, loneliness, fatigue, helplessness, shock, and surprise are felt. The closeness of the deceased, the attachment style, the way of death, personality traits, and sociocultural characteristics affect the grieving process. There is no definite answer to the question of when the grieving ends.

With grief counseling, some people who cannot resolve their feelings about their loss are helped to bring their grief to a more successful conclusion. The purposes; Increasing the reality of the loss, helping the client overcome various situations that prevent them from re-adjusting after the loss, and making the client feel comfortable saying goodbye to the lost person appropriately and reinvesting in life. At this point, it is important to identify risky groups. If most of the risks are detected in the evaluation performed at the 4th week after the loss, this person is considered to need intervention. Conditions such as self-blame, longing, anger, unemployment, low sociocultural level, lack of social support, and loneliness are among the risk factors (3).

References

1. Neimeyer RA. Meaning reconstruction & the experience of loss. American Psychological Association; 2001.
2. Prof. Dr. Vamık Volkan, Elizabeth Zintl. Kayıptan Sonra Yaşam. 1. bs. 22 s.
3. J. William Worden. Yas Danışmanlığı ve Yas Terapisi. Ankara Üniversitesi Tıp Fakültesi Yayınları; 31 s.

WHAT THE PANDEMIC BRINGS: GRIEF WHICH IS GETTING LONELY

Uzm. Dr. Alper Bülbül

University of Health Sciences, Istanbul Erenkoy Mental Health and Neurological Diseases Training and Research Hospital

Grief finds a place in our lives, in our hearts. During the grieving process, we reconsider our relationship with the deceased person and differentiate this relationship. This process is complex, multi-layered and consists of different phases.

The bereaved person learn to understand their loss and accept their grief by going through certain stages and with the help of different rituals depending on the culture. Over time, the relationship with the lost person is permanently internalized. For many people, adapting to loss happens naturally.

However, due to the complexity and multi-layered nature of the process, it may derail in certain situations.

This usually happens because there is something about the meaning or experience of the loss that is troubling in a way that the bereaved person is unable to resolve. This might be related to characteristics of the bereaved person, the specialness of the relationship with the person who died, circumstances of the death, or the context in which the death occurred.

The COVID-19 pandemic is one of the worst public health crises of the century, with over 5 million deaths worldwide and even more bereaved.

There are studies that have compared loss due to a pandemic to a sudden and unexpected traumatic loss during a natural disaster.

The process has its own characteristics and difficulties due to the sudden, unexpected and rapid course of death, as well as unusual death conditions.

For this reason, the grief reactions that occur in the families and relatives of the people who lost their lives in this pandemic may also have their own characteristics and difficulties.

Factors such as multiple deaths in the family, uncertainties in the diagnosis and treatment process, the inability to fulfill the rituals after the loss due to the pandemic, lack of social support, and the existence of a life threat events could make the grieving process very complex.

References

1. Çelik, F., & Gündüz, N. (2020). Covid 19 pandemisinde yas. *Klinik Psikiyatri Dergisi*, *23*(1), 99-102.
2. Goveas, J. S., & Shear, M. K. (2020). Grief and the COVID-19 pandemic in older adults. *The American Journal of Geriatric Psychiatry*, *28*(10), 1119-1125.
3. Gesi C, Carmassi C, Cerveri G, Carpita B, Cremone IM, Dell'Osso L. Complicated grief: what to expect after the coronavirus pandemic. Frontiers in psychiatry. 2020;11:489.

OTİZM BİR ÇOCUKLUK DÖNEMİ PROBLEMİ DEĞİLDİR

Dr. M. Yankı Yazgan

Otizm (Spektrum Bozukluğu (OSB) bir çocukluk dönemi problemi değildir. OSB genellikle çocuklukta, daha doğru deyişle gelişimin başlangıç aşamalarında fark edilebilen, ama yaşam boyu bir tanı olarak devam edip etmemesinden bağımsız olarak etkisi süren bir gelişim problemidir. Gelişimin değişik aşamalarında ve hayatın değişik evrelerinde başlangıçta saptanmış olan problemin değişik yüzleri ile karşılaşırız. Bazı özellikler zaman içinde hafifler ya da kaybolurken, yerine veya "yanında" yeni durumlar belirir. Yeni durumların veya eski durumların yeni yüzlerinin ortaya çıkması şaşırtıcı olmamalı, zira hayatın bireyin ve gelişiminde etkisi olanların karşısına çıkarttığı beklenen ve beklenmedik durum ve görevler, bireyde varolan yatkınlıkları ve kırılganlıkları ve "güçler ve güçlükler"i hayatı tüm boyutlarıyla yaşamasına engel haline taşıyıverir. Zaman zaman aynı güçler ve güçlükler engellerin aşılmasına araç olur.

OBSESSIVE COMPULSIVE DISORDER FROM NEUROBIOLOGY TO TREATMENT

M. Hakan Türkçapar
Social Sciences University of Ankara

Obsessive compulsive psychiatric disorders are one of the most studied disorders in terms of diagnosis and treatment due to the diversity in their clinical manifestations. Studies on obsessive-compulsive disorder, which were separated from anxiety disorders with DSM-5 and gathered under a separate class under the name of obsessive compulsive disorder and related disorders, gained a little more momentum after this division.

OCD is a chronic disease with long periods of discomfort, rare spontaneous recovery, and usually with increases and decreases if left untreated. Obsessive compulsive disorder is a psychological disorder in which genetic neurobiological factors and psychological factors play an equal role. It is accepted that the share of inheritance in obsessive compulsive disorder is about 40% of OCD, with this rate obsessive compulsive disorder is a moderate inherited mental disorder. A higher genetic heritability has been reported, particularly in childhood-onset OCD. The genetic factors involved in the formation of OCD are not single-gene or unidimensional. OCD is a complex disorder, with multiple genetic contributions with small effect size contributing to its occurrence. The rate of OCD in first-degree relatives of adults with OCD is approximately twice that of first-degree relatives of adults without OCD; In addition, among first-degree relatives of people with childhood or adolescence-onset OCD, the incidence of OCD increases 10 times. Familial transmission is due in part to genetic factors (eg, the comorbidity rate is 0.57 for identical twins versus 0.22 for fraternal twins).

In the brain imaging examinations of individuals with OCD, it has been determined that there is an increase in activity in the brain, in the regions of the brain called the orbitofrontal cortex and caudate nucleus. These biological changes detected by brain imaging can be both a cause or a result in OCD.

The behavioral model, which is one of the most important theories explaining OCD, says that classical conditioning and operant conditioning play a role in the formation and maintenance of OCD. Cognitive theories, on the other hand, focus on the cognitive factors that play a role in the formation of OCD, namely perceptions, thoughts and beliefs. Cognitive therapy researches cognitive features such as intolerance of uncertainty, exaggerated responsibility, thought-action fusion, etc., which are considered to play a role in the formation and maintenance of OCD, and tries to change them in treatment.

There are two methods that have been scientifically proven to be effective in the treatment of the disease. The first of these methods is drug treatments. The main drugs that have been scientifically shown to be effective in the drug treatment of OCD are serotonin reuptake inhibitor group drugs, which is a kind of antidepressant. Combined drug treatments, sometimes by adding antipsychotic and anxiolytics (anxiolytic) to these drugs, can also be used in resistant OCD. The second method that has been scientifically proven to be effective in OCD is cognitive behavioral therapy.

FROM NEUROBIOLOGY TO THERAPY IN SOCIAL ANXIETY DISORDER

Eda Aslan

Social anxiety disorder (SAD) also known as social phobia, is a common disorder

characterized by marked fear or anxiety of one or more social situations. Exposure to a social situation almost always provokes anxiety or even panic attack in the affected individual who concerns of being judged negatively by others and feels excessive fears of scrutiny, embarrassment, and humiliation in social or performance situations. Avoiding the social situations due to intense anxiety results in functional impairment in social, occupational, or other realms.

Both heredity and environment are involved in the development of social anxiety disorder (SAD) although findings for the effects of specific genes have not been regularly replicated. Studies of the pathogenesis of SAD have aimed attention on a various interacting neurohormonal and neurotransmitter systems, and on neurocircuitry which involves the amygdala, insula and prefrontal cortex. The amygdala plays an important role in the fear response in SAD like the other anxiety disorders and abnormalities in amygdala pathways can affect the learning and expression of fear conditioning. Cortico-striato-thalamo-cortical (CSTC) circuits seems to play a central role in moderating the symptoms of worry and various neurotransmitters are associated with the circuits that regulate the anxiety symptoms. The known neurobiological regulators of the amygdala include the neurotransmitters GABA, serotonin,8 norepinephrine, and the voltage-gated calcium channels.

The treatment options for SAD are all target these neurotransmitters to mediate . Benzodiazepine is not as commonly accepted as it might use or generalized anxiety disorder and panic disorder Beta blockers may be effective for some patients with some types of social anxiety, such as performance anxiety. Cognitive behavioral psychotherapy is a useful intervention, often more effective in combination with drugs.

AUTOMATIC DIAGNOSIS OF ALZHEIMER'S DISEASE USING SPEECH TECHNOLOGIES

Saadin Oyucu
Adıyaman University, Faculty of Engineering, Department of Computer Engineering, Adıyaman

Abstract
Studies carried out for the diagnosis of Alzheimer's disease in underdeveloped and developing countries are not sufficient [1]. Failure to diagnose the disease early and accurately causes clinical studies to fail. It is also believed that disease pathology is at work before cognitive decline becomes apparent. For this reason, there is a need for an automatic diagnosis system that is easy to perform, low cost and can be repeated at regular intervals in the diagnosis of Alzheimer's disease. The sounds produced by interfering with multiple organs in the vocal tract and the speech act that requires the coordinated activity of the brain region provide important information in the diagnosis of Alzheimer's disease. It is also known that speech-based tests such as verbal fluency play an important role in the diagnosis of the disease [2].

The act of speech basically provides valuable information in terms of acoustics and linguistics. By using acoustic signal processing techniques, speech features such as the number of pauses, pause duration and pitch changes can be easily obtained from a speech data. In addition, by evaluating the expressions in the speech (vocabulary, unique word, sentence complexity, word repetition frequency), researchers are provided with information about the speaker. In order to evaluate the expressions in the speech, the expressions in the speech must be manually transcribed. Manual transcription is costly in terms of both labor and time. For this reason, Automatic Speech Recognition (ASR) systems with the ability to automatically transcribe speech are used [3].

Interview recordings obtained in disease detection can be automatically translated into text by ASR systems. The number of words, the number of different words, the complexity of the sentence and the frequency of repeated words can be determined on the speech content transferred to the text. In the light of the information obtained, the disease status of the speaker will be analyzed. In addition, the progression of the disease can be controlled by recording the results of regular tests performed automatically. However, the speech-based diagnostic method presents some difficulties as it requires interdisciplinary work. One of these challenges is the difficulty of developing voice processing technologies and ASR systems, and the other is to obtain evidence that accurate diagnosis is possible in speech-based feature examinations. Once these two challenges are overcome, it will be possible to develop an automated disease diagnosis system that researchers can easily use.

References

1. R. Sadeghian, J. D. Schaffer, and S. A. Zahorian, "Towards an Automatic Speech-Based Diagnostic Test for Alzheimer's Disease," Front. Comput. Sci., vol. 3, no. April, pp. 1–11, 2021.
2. Ö. Aki, B. Alkan, T. Demirsöz, B. Velibaşoğlu, "Yaş, Cinsiyet ve Eğitim Düzeyinin Fonemik ve Semantik Sözel Akıcılık Testi Puanları Üzerinde Etkisi," Scholar.Archive. vol. 9, no. 10, 2021.
3. H. Polat, S. Oyucu, "Building a speech and text corpus of Turkish: Large corpus collection with initial speech recognition results," Symmetry (Basel)., vol. 12, no. 2, 2020.

SCHIZOPHRENIA AND LANGUAGE FUNCTIONS

Emre Mısır
Başkent University Faculty of Medicine, Department of Psychiatry, Psychiatry Specialist

In addition to core symptoms such as psychotic symptoms and cognitive impairment, schizophrenia also causes impairment in the language domain. At the same time, impairment in thought processes is seen as the most basic feature of schizophrenia. According to linguists, language and thought are separate modular functions, whereas in neuroscience perspective language is considered as a output of thought. Investigation of language functions in schizophrenia in the literature aims to shed light on thought disorders.

In schizophrenia, impairments at the level of semantic, syntax, pragmatic and phonological processing have been demonstrated. These disorders are even more pronounced in patients with formal thought disorder (FTD). An increase in semantic network activity and increased activation in the left fusiform and superior temporal gyrus (STG) during semantic indirect priming have been shown (Kircher et al, 2018). At the same time, a positive correlation was found between right middle temporal gyrsu (MTG) activity and positive FTD score in the resting state. Hyperactivation in the semantic network causes the choice of words to go beyond certain rules, and this is held responsible for loosening in associations. As a matter of fact, loosening in associations and encoherence were found to be associated with hyperactivity of the middle temporal gyrus in particular. An increase in MTG and left anterior cingulate cortex (ACC) activity during peculiar word use indicates difficulty in error detection and impairment in associative semantic processing. Thus, the use of words that are semantically related but disconnected from the context occurs (Chen et al, 2021). At the same time, as the severity of positive FTD increases, the decrease in frontoparietal network cortical thickness and salience network spatial coherence may be associated with a decrease in error tracking and control of semantic diffusion (Palaniyappan, 2021).

Impairments in phonological processing and understanding of prosody have also been reported in schizophrenia. A recent meta-analysis found decreased activity of the right primary auditory cortex and mPFC, and decreased auditory cortex-insula connectivity during emotional prosody processing.

Psychotic symptoms and language functions are also thought to be related. In schizophrenia, impairment in identifying the source of sentences read by themselves and others has been demonstrated. When self-read sentences were listened to in healthy controls, an increase in STG activity was found compared to sentences read by others. There was no difference in patients with hallucinations. This may be a mechanism in the self-other distinction failure and the perception of inner speech as hallucinations.

References

1. Kircher T, Bröhl H, Meier F et al (2018). Formal thought disorders: from phenomenology to neurobiology. The Lancet Psychiat 5: 515-526
2. Chen J, Wensing T, Hoffstaedter F et al (2021). Neurobiological substrates of the positive formal thought disorder in schizophrenia revealed by seed connectome-based predictive modeling. Neuroimage: Clinical 30:102666
3. Palaniyappan L (2021). Dissecting the neurobiology of linguistic disorganization and impoverishment in schizophrenia. Semin Cell Dev Biol S1084-9521(21)00235-4. doi: 10.1016/j.semcdb.2021.08.015. Epub ahead of print.

KANSERLİ ÇOCUK VE ERGENLERDE GÖRÜLEN PSİKİYATRİK BOZUKLUKLAR

Semra Yılmaz

Geçmişte çocuklardaki kanser tedavisinde sağ kalıma odaklanırken, iyileşme oranlarının artması ile kanserin kendisinin veya tedavisinin beraberinde getirdiği çocuk ve aile üzerine yaşam kalitesini etkileyen fiziksel ve psikolojik etkilerin de dikkate alınması gerektiği ortaya çıkmıştır. Bu sebeple çocuk ve gençlerin kanser tedavisi alırken duygusal ve davranışsal sorunlarını, psikolojik ihtiyaçlarını, aile, okul ve sosyal yaşamlarındaki zorlukları kapsamlı şekilde değerlendirmek önemli hala gelmiştir.

Araştırmalar, çocukluk çağı kanseri olan çocuk ve gençlerin ve ebeveynlerinin hastalık boyunca ciddi psikolojik sıkıntı yaşayabileceğini göstermektedir. Mevcut literatürler psikososyal desteğin, psikiyatrik tedavilerin psikolojik sıkıntı belirtilerinin azalmasında etkili olduğunu göstermektedir.

KANSER HASTALARINDA PSİKOTERAPİ YAKLAŞIMLARI

Fatma Akyüz Karacan

Kronik hastalıklardan biri olan kanserin, hastaların fiziksel sağlıklarının yanı sıra psikolojik sağlıklarını da olumsuz yönde etkilediğine işaret etmektedir. Farklı tür kanser tanısı olan kişilerde karın ağrıları, yorgunluk, uyku sorunları, cinsel yaşam sorunları, engellenme, umutsuzluk, öfke kontrolünde zorluk, beden imgesinde bozulmalar, uyum bozuklukları, depresif bozukluklar ve kaygı bozuklukları yaygın olarak görülen sorunlardır.

Kanser tanısı olan kişilere uygulanan psikolojik müdahaleler incelendiğinde psikoeğitim, destekleyici tedavi, öz yönetim stratejileri, telefon/internet temelli müdahaleler, motivasyonel görüşme teknikleri, bilişsel davranışçı terapi, farkındalık temelli müdahale programları, problem çözme ve sosyal beceri eğitimi, varoluşçu yaklaşım ve logoterapi, sanatsal terapi, kabul ve kararlılık terapisi gibi tedavi yöntemlerinin kullanıldığı görülmektedir.

PSİKO-ONKOLOJİDE GÜNCEL TEDAVİ YAKLAŞIMLARI

Sevda Gümüş Şanlı

Global kanser yükü sigara, çevresel kirlilik, obezite, sağlıksız beslenme, fiziksel hareketsizlik, enfeksiyon (hepatit, helicobacter pylori ve human papilloma virüs), oral kontraseptifler gibi risk faktörlerinin prevalansının yükselmesine bağlı olarak artış göstermektedir . Global kanser yükü (GLOBOCAN) 2012, tahmini 14.1 milyon yeni kanser vakası olduğunu raporlamışken, bu sayının gelecek 20 yıl içerisinde %70 oranında artış göstereceğini bildirmiştir.

Kanserin tüm dünyada prevelansı birbirine benzerken, kanserin türü ve takip eden tedavisi birbirinden farklılık göstermektedir. Gelişmiş ülkelerde genel olarak hayatta kalma oranları standart sağlık hizmetlerine erken ve kolay ulaşım nedeni ile yüksektir.

Yüksek kalitede kanser tedavisi programlarına ulaşabilmek için onkoloji ile ilgilenen tüm sağlık çalışanlarının psikososyal konularda eğitim alması ve ülkelerin ulusal kanser eylem planına psiko-onkoloji programlarını ve multidisipliner müdahaleleri dahil etmeleri bir zorunluluk olarak gözükmektedir. Bu bağlamda, psikofarmakoloji, kansere ikincil olarak gelişen psikiyatrik hastalıkların tedavisinde psikotropik ajanların kullanımı ve bunun yanısıra psiko-onkoloji uygulamalarında psikofarmakolojik araştırmalar sonucunda çıkan yeni verilerin kapsamlı bir şekilde güncellenmesi açısından da birkaç eğitim alanından biri olarak durmaktadır.

Kaynaklar

1. Bercaw GN (2000). Advocacy training: A look toward the future for pediatric cancer patients and their families. Dissertation Abstracts International: B. Sciences & Engineering, 60: (9-B).
2. Greer JA, Park ER, Prigerson HG, Safren SA. Tailoring cognitive-behavioral therapy to treat anxiety comorbid with advanced cancer. J Cogn Psychother 2010; 24:294–313.
3. Baider L, Peretz T, Hadani PE, Koch U. Psychological intervention in cancer patients: a randomized study. General Hospital Psychiatry. 23(5), 272-277; 2001.
4. Coster S, Li Y, Norman IJ. (2020). Cochrane reviews of educational and self-management interventions to guide nursing practice: A review. Int J Nurs Stud 110:103, 698. doi: 10.1016/j. ijnurstu.2020.103698.
5. Latest world cancer statistics – GLOBOCAN 2012: Estimated Cancer Incidence, Mortality and Prevalence Worldwide in 2012.

PREDOMINANTLY PSYCHOLOGICAL SIGNS AND SYMPTOMS

Burçin Çolak

Factitious Disorder is a controversial psychiatric disorder that leads to many clinical problems such as the diagnostic and treatment processes as well as potential judiciary requirements. The nature of the disorder lies between intrinsic motivation to have a deep sick role to malingering, which can be challenging to make proper clinical interventions. In factitious disorder imposed on self with predominantly physical signs and symptoms, there can be some opportunity for opening a therapeutic window of opportunity such as recognizing the producing the psychical symptoms such as finding insulin needles for hypoglycemia of unknown origin. This can lead the clinician for revising the diagnosis or treatment process. Also, there are some kinds of sick role styles that can be enlightening to an experienced clinician such as the attitude of the patient's affective, cognitive, or behavioral conduct with his complaints as well as the medical team. However, these types of scarce incentives in factitious disorder imposed on self with predominantly physical signs and symptoms can be completely missing in factitious disorder imposed on self with predominantly psychological signs and symptoms. For instance, the controversial division between mind & body in the former gets lost in the latter. The patient suffers from some kind of depression or disturbing hallucinations that is mostly diagnosed via self-report. The division of the symptoms between the somatic and psychic origin gets lost in the latter form of factitious disorder. Being depressed, having depression, and reporting depression cannot be easily distinguished. All these factors can make factitious disorder imposed on self with predominantly psychological signs and symptoms a challenging diagnosis. The main approach to the management of factitious disorder imposed on self with predominantly psychological signs and symptoms can be summarised as 1) primum non nocere (misdiagnose and treatment), 2) understanding the psychodynamics of producing the psychological symptoms and 3) legal issues.

TRANSITION TO ADULTHOOD: EMPLOYMENT, EDUCATION, FAMILY, FRIENDSHIP, AND MARRIAGE IN INDIVIDUALS WITH NEURODEVELOPMENTAL DISORDERS

Onur Tuğçe Poyraz Fındık

The period after leaving high school is a time of newly found independence and exploration for many young adults, which often involves the pursuit of education and employment. Neurodevelopmental disorders (NDDs) are a group of multifactorial disorders related to an impairment of cognitive and social development, with early onset and symptoms extending into adulthood. The transition into adulthood is a special period of high vulnerability for individuals with NDDs who have ongoing problems with communication and social skills, organizational, decision-making, planning difficulties and other comorbid psychiatric disorders. A substantial number of them are not ready to make adult decisions, take care of their own practical needs, or support themselves financially. Moreover, public assistance for young people with NDDs and their families decreases during this period, because they usually receive the special support they need in the school-based system. With the end of high school, selection, accessibility, and continuity of suitable services for those are major challenges, and therefore, the end of high school is a “detachment point” from social life for individuals with NDDs. It is particularly important for clinicians to recognize NDDs as conditions with lifelong implications such as employment, university, friendship, and marriage rather than childhood-specific disorders. On the other hand, the literature of NDDs has focused on the childhood characteristics of these disorders. Given the rapid increase in prevalence of NDDs, it is important to consider the future prospects of these adults already living with conditions and the children and adolescents who are quickly aging into adulthood.

The support needs of individuals with NDD change over time, depending on the context of the current situation (at home, school, and work). While educational life includes relatively flexible hours and low responsibilities to others, the transition to employment adds a new and complicating dimension to life. Also, additional expectations such as maintaining social and close relationships create a cumulative effect in adulthood. Therefore, the clinical evaluation process of an individual with NDD requires an approach beyond diagnostic classification and determination of symptom severity. Nevertheless, NDDs are defined by criteria based on different behavioural patterns in current diagnostic systems. But, many clinical features of these disorders overlap, such as deficits in social skills and executive function, and each group contains individuals with highly heterogeneous phenotypic features. Consequently, it is a critical step to define the main problem areas that affect daily functioning and the strengths and weaknesses of the individual with NDDs in the planning of individual specific treatment and supportive interventions. This presentation discusses young adults with NDDs and their unique ongoing difficulties they face during the stage of transition into adulthood, with case reports, clinical experiences, and the expanded literature about adults with NDDs. Additionally, it is aimed to discuss in detail overlapping phenotypic characteristics among different diagnostic groups and the importance of a transdiagnostic approach in the context of their effects on daily life functioning.

THE ROLE OF A PSYCHIATRIST IN THE GENDER AFFIRMATION PROCESS: THE CASE WHEN THE PERSON AND HER FAMILY DO NOT COOPERATE

Hayri Can Özden

Department of Psychiatry, Faculty of Medicine, Hacettepe University, Ankara, Turkey

Although the role, duty, and responsibility of the healthcare professional in the gender affirmation process can be individually discussed for each case, the most obvious conflict is experienced during the assessment and assistance to the people with gender dysphoria presenting with additional health issues or when they are uncooperative. The role of the psychiatrist in this process, alternative working models, and the contribution that can be made will be discussed through a case presentation.

The patient, who is currently 20 years old, is assigned male at birth. She applied to a psychiatry clinic for the first time at the age of 15 due to gender dysphoria that is exacerbated by puberty-related changes. The patient identified as a woman starting from her earliest ages and experienced severe difficulty in gender expression. She first applied to the child psychiatry department without notice to her family, and then she had to inform them. Her family had difficulties in accepting her gender and rejected her requests for gender affirmation. Thus, they had difficulties in establishing cooperation with medical staff from the first day. Despite their initial reaction, in the second medical center they applied, they provided informed consent for the “puberty suppression”, which has been used recently for teenagers with the condition if they fulfill the required criteria. After a short follow-up period under puberty suppression with reversible agents, the patient dropped out due to some difficulties and life events. A few years later she re-applied to the adult psychiatry clinic. From this period, the patient’s non-compliant attitude and inability to cooperate caused significant problems.

The follow-up gender affirming treatment of the patient was often interrupted since she was not cooperating. During the course, she underwent some medical interventions not recommended by the team. The efforts by the psychiatrist in building cooperation with the family members, some of which posed a serious threat to the well-being and health of the patient, frequently failed, often due to the uncooperative attitude of the patient. Therefore various disruptions occurred in the transition process. The psychosocial support that could have been provided during adolescence and adulthood, and the role and the legal responsibility of the psychiatrist in the process of medical interventions will be discussed. Also, the dilemmas and difficulties experienced by the psychiatrist as a physician and a therapist, and the positive and negative aspects of conducting the process with different models will be discussed with the contribution of the participants at each stage of the follow-up.

References

1. Başar K, Yüksel Ş, Çocukluktan yeti kinliğe cinsiyet kimliği ile ilgili sorunlar: uygun değerlendirme ve izlem, Psikiyatride Güncel, cilt.4, sa.4, ss.389-404, 2014
2. Solanki P, Cabrera DC, Barton C, Locke P, Cheung AS, Spanos C, Grace J, Erasmus J, Lane R (2022) Gender-affirming hormone therapy for the trans, gender diverse and nonbinary com- munity: coordinating World Professional Association for Transgender Health and informed consent models of care, Transgender Health X:X, 1–12, DOI: 10.1089/trgh.2021.0069.
3. Standards of Care for the Health of Transsexual, Transgender, and Gender- Nonconforming People, 7th ed. WPATH, 2012

EMOTIONAL BRAIN

Yasemin Hoşgören Alıcı

Social cues, interactions, and relationships dominate in the landscape of emotions. Emotional experiences play an important role in buffering stress, promoting positive affect, and repairing mood. So, emotions play a cardinal role in the human experience. For this reason, it has been curiously studied by many fields of science and its underlying mechanisms have been tried to be understood. Although Recently research provides many insights into the organization of emotions in the brain, no definite consensus has been reached. The problem starts with the question of "what is an emotion?". Some researchers consider basic emotions like "anger, disgust, fear, happiness, sadness, and surprise" exist and are associated with facial expressions and patterns of autonomic activity. Some research highlights the differences and overlap between instances of particular emotions. The view that almost everyone agrees with is that emotions are processed through widely dispersed networks in the brain. Which neural circuits are involved at what points is also the most controversial area? Do emotions occur cortical or subcortical? Or are emotions constructed from domain-general building blocks not specific to any particular emotion?

According to a widely supported view in the last period, the generation of emotions is subcortical but other processes that need to regulate emotion are evolutionary newer and achieved by cortical brain regions. Emotions have their roots early in development, over time they change and mature. Although the maturation process is poorly understood changes in hormones, cognitive control, and experience would affect the connectivity of the brain that will use in the emotional process. Emotion resumption also functions as state and trait. accordingly, the brain region may also change according to the regulation strategy it uses.

Darwin emphasizes the shared origins and essential continuity of emotions in humans and animals. Recently Panksepp supported this idea and claim that we share basic emotional systems with mammalians. But what are the essential neural system for an emotional response? Can the perception, expression, and experience of emotion be generalized?

In this talk, where these and similar questions will be discussed, we invite you to think about our emotions and our brain. Emotions form the basis of our behavior and decisions, although their definition and content may change according to the theory in which it is addressed. For this reason, knowing how it works and being able to produce ideas on it constitute the first step in understanding mental illness.

EXECUTIVE FUNCTIONS AND REGULATION OF EMOTION

Müge Kuzu Kumcu[1,2]
[1]*Department of Neurology, Lokman Hekim University School of Medicine, Ankara, Turkey*
[2]*Department of Interdisciplinary Neuroscience, Ankara University, Ankara, Turkey*

Executive functions, a unique control system of the human brain, can also be called frontal lobe functions. It works like a top processing unit. executive functions; refer to high-level cognitive functions that include organizing information, making learned information available for use, executing two or more mental functions simultaneously, stopping a prepared behavior, controlling memory and attention, and directing the behavior to be flexibly organized and included in forwarding planning. Within the scope of the executive functions, there are firstly determining a goal, then imagining the moves towards the goal, the obstacles that may arise, starting the work for the determined purpose, and creating alternative plans when unforeseen obstacles are encountered. Response inhibition, cognitive flexibility (set change), planning, and organization are essential parts of executive functions. Executive functions; consist of four different components as planning and decision making, will, action towards purpose, and effective performance. These components take place as a whole and take part in different activities related to behavior. Thus, our behavior becomes organized, strategic, planned, orderly, and purposeful.

Emotion regulation (ER) is related to understanding and managing emotions as a concept. It includes using effective skills and strategies to cope with negative emotions. ER is about attempts to influence emotions, defined as positive or negative states. The five strategies in the proposed model for ER; situation selection, situation modification, attention span, cognitive change, and response modulation. Stuation selection is a choice between two or more states. Situation modification is an individual’s attempt to manipulate a situation to change the emotional impact of that situation. Attention span is the directing of attention to regulating the emotional response in the face of a certain situation. After focusing on a certain aspect of an emotional situation, cognitive change can be considered as choosing among many possible meanings attached to it. Response modulation is the effort to influence this response after the emotion has arisen. Suppression and cognitive reappraisal are the main mechanisms used for emotion regulation. Cognitive reappraisal can be roughly defined as changing one’s way of thinking to regulate the emotional impact of a situation. Suppression can be defined as reducing the expression of an emotional state.. Emotion regulation systems can be activated automatically or voluntarily. The unconscious memory process derived from previous encounters with the stimulus and the stimulus-related content influences a person’s ability to perceive and classify the stimulus. This unconscious process before the behavior that will occur as a result of the stimulus creates a motivational situation for the person to defend or enjoy, depending on the current situation, and this situation prepares the person to give appropriate reactions at the appropriate time. Involuntary emotion regulation, that is, in processes such as voluntary behavior control, attentional orientation, and cognitive change, the person consciously chooses these ways.

DOES STROKE PLAY WITH YOUR EMOTIONS?

Safiye Zeynep tatlı

It is known that depression and anxiety disorders are common after stroke as a result of impairments in physical, social and cognitive function. In addition there is evidence that emotion perception and emotion regulation, the ability to evaluate and influence when and how intensely one's own emotions are experienced, are also impaired in patients with stroke1,2.

The lesion caused by the stroke may affect the brain networks responsible for emotion regulation resulting in impairment of these functions. Moreover a reactive response to the stroke may also result in emotion dysregulation either directly or indirectly through depression3. There are data in the literature indicating that emotion dysregulation is common after prefrontal cortex (PFC) lesions from stroke. It has been reported that the range of response modulation is reduced in patients with right PFC damage and performance in the suppression of facial emotional expressions task is associated with cognitive inhibition4. Concrete behavior, the inability to disengage from immediate experience to manipulate thoughts, is a common feature of frontal lobe lesions and affects reappraisal, a type of emotion regulation strategy. A patient with concrete behavior after left PFC stroke whose overall cognitive function was relatively preserved was reported to be completely unable to spontaneously generate reappraisals. But her capacity to reappraise improved once external support was offered5. There is a case report suggesting that the impairment in executive functions after left dorsolateral PFC damage may have an impact on processes such as emotion reactivity and emotion regulation6. This finding is consistent with the literature suggesting that executive functions play a role in emotional responsiveness and are central to emotion regulation7,8.

Impairments in emotion regulation are common among individuals with stroke and adversely affect quality of life and social relationships. However few studies have been conducted in the field of neuropsychiatry on this subject and most of the available data have been obtained from case reports. Examining different profiles of cognitive and emotional impairment, lesion and neuroimaging studies may contribute to the understanding of the neural basis of emotion regulation strategies. Thus, it may be possible to understand the issues at the border of cognition and affect, and define new rehabilitation approaches.

References

1. Carter, C. S. (2009). The ups and downs of emotion regulation. Biological Psychiatry, 65(5), 359-360.
2. Robinson, R. G. (2003). Poststroke depression: prevalence, diagnosis, treatment, and disease progression. Biological psychiatry, 54(3), 376-387.
3. Scott, C. L., Phillips, L. H., Johnston, M., Whyte, M. M., & MacLeod, M. J. (2012). Emotion processing and social participation following stroke: study protocol. BMC neurology, 12(1), 1-7.
4. Salas, C. E., Castro, O., Yuen, K. S., Radovic, D., d'Avossa, G., & Turnbull, O. H. (2016). 'Just can't hide it': a behavioral and lesion study on emotional response modulation after right prefrontal damage. Social Cognitive and Affective Neuroscience, 11(10), 1528-1540.
5. Salas, C. E., Gross, J. J., Rafal, R. D., Viñas-Guasch, N., & Turnbull, O. H. (2013). Concrete behaviour and reappraisal deficits after a left frontal stroke: A case study. Neuropsychological rehabilitation, 23(4), 467-500.
6. Salas, C. E., Radovic, D., Yuen, K. S., Yeates, G. N., Castro, O., & Turnbull, O. H. (2014). "Opening an emotional dimension in me": Changes in emotional reactivity and emotion regulation in a case of executive impairment after left fronto-parietal damage. Bulletin of the Menninger Clinic, 78(4), 301-334.
7. Ochsner, K. N., Ray, R. R., Hughes, B., McRae, K., Cooper, J. C., Weber, J., ... & Gross, J. J. (2009). Bottom-up and top-down processes in emotion generation: common and distinct neural mechanisms. Psychological science, 20(11), 1322-1331.
8. Barkley, R. A. (2001). The executive functions and self-regulation: An evolutionary neuropsychological perspective. Neuropsychology review, 11(1), 1-29.

FEMINIST THERAPY CASE PRESENTATION: A FEMALE CASE WHO WAS EXPOSED TO GENDER BASED PSYCHOLOGICAL VIOLENCE

Ayşe Nur Oğuz

The Case G.G:
A 24-year-old female patient presented with depressive complaints and temper tantrums that had increased for the last month.

She was born in a family dominated by the traditional patriarchal point of view and was left in the village by her family at the age of 5 to take care of her grandfather and grandmother. She started to live with her family again at the age of 12 and got married 4 years ago.

She was expected to consent to the expectations and demands of the family and to be happy with her current life and not cause any problems. The female patient's expression of any negative emotion or opposition to expectations, and her demands to have equal rights with her husband were severely suppressed by the family, resulting in the patient being accused of ingratitude and dissatisfaction.

She also had a hard time making sense of both her past traumatic experiences and the stressors in her current life during the therapy. She was trying to cope with the intense feelings of abandonment by constantly saying "Maybe I don't have a problem, I'm making everything bigger" and directing her anger towards herself. She was experiencing intense feelings of guilt, seeing her own motherhood as inadequate, and harming herself during tantrums.

During the psychotherapy process, which lasted for about 7 months, the patient was seen once a week at the beginning, then once every two weeks. The patient continued to experience the traumatic effects of the sudden separation in her childhood in the form of loneliness and abandonment concerns throughout her life. She grew up in a patriarchal family and while she was feeling suffocated in her marital life with a patriarchal couple, she continued to experience intense anxiety caused by distance from her husband. In the later stages of therapy, the patient's depressive complaints and tantrums regressed, she began to express herself more clearly, but the patient abruptly ended the therapy due to separation anxiety possibly triggered by the negative attitude of her husband and family about the patient's going to therapy.

From a feminist psychotherapy point of view, we wanted to draw attention to the inequalities in the unequal power relationships, how these inequalities are normalized, and the negative effects of social pressure and inequalities on women's mental health. In addition, we wanted to draw attention to the relationship between the patient's past traumas and mental conflicts and the state of staying in the current traumatic relationship, and the importance of raising awareness of the therapist at this point.

This case was followed up and supervised within the scope of Supportive Psychotherapy Training of the Turkish Psychiatric Association, with the consent of the patient, and was prepared as a case report by hiding the identity information.

ZABEL YESAYAN: WITNESSING TO THE CATASTROPHIC TIMES

Ayşe Devrim Başterzi, Assoc. Prof.,
Psychiatrist, İstanbul

Zabel Yesayan was born on February 4, 1878, as Zabel Hovhannessian, in the Silahdarbahçe Street in Istanbul. She was one of the greatest Armenian feminist writers of the late 19th century Ottoman era. Zabel's literary career began in 1895 with the publication of her first poem, Yerk ar kişer (Praise to the Night). She moved to Paris to study literature and philosophy at the Sorbonne University in same year. She stayed Paris for many years, got married with a painter, Dikram Yesayan, and had two children, Sofi and Hrant. On July 24, 1908, the Young Turks successfully overthrew the Sultan and took control of the Ottoman government. Many Armenians supported this shift, because the Young Turks promised equality for all groups within the empire, including Armenians. After the Young Turk Revolution in 1908, Zabel returned to Istanbul. Young Turks were in consensus that democratization was required for Ottomanism and they came to power with a promise of equality for all. However, tensions continued within the empire, as former supporters of the Sultan rebelled in a violent backlash against Armenian equality. A year after the Young Turk Revolution, army and supporters of Caliphates perpetrated a massive massacre of Armenians and other Christian minorities in Adana and sourrounding villages (Cilicia). After the 1909 massacres of Adana, she went to Cilicia to provide relief for the orphans and wrote her eyewitness testimony, In the Ruins, which was widely read. Interestingly, in this book Yesayan addressed "her compatriots" — both Armenian and Turkish. In 1912, during the Balkan Wars, Yesayan penned a treatise titled -Enough! - that called for peace. Yesayan criticizes patriarchy, social injustice, racism and capitalism in her works. Until 1915, her socio-political activism resurfaced, and she wrote prolifically. Yesayan was the only woman on the list of Armenian intellectuals targeted for arrest and deportation on April 24, 1915. She escaped to Bulgaria and then Baku and bore witness to the Medz Yeğern through published accounts and reports to the 1919 Paris Peace delegation. After moving to Armenia in 1933, Yeseyan stood up to another empire, this time the Soviet Union, where she spoke out in support of other Armenian writers. During Stalin's purge, she was arrested and imprisoned, and died under mysterious circumstances. In this presentation, the herstory of a resilient feminist and peace activist woman who witnessed the terrible massacres and barely saved her life from a mass disaster will be discussed in the context of surviving and witnessing to the psychological trauma.

References

1. Akcam T (2012) 'Young Turks' Crime Against Humanity: The Armenian Genocide and Ethnic Cleansing in the Ottoman Empire, Princeton University Press.
2. Çakır S (2007) Feminism and feminist history-writing in Turkey: The discovery of Ottoman feminism. Aspasia 1: 61–83.
3. Djoulakian H (2017) "Feminist Cultural Analysis of an Invisibilized Genocide: Gender, Disability, and Memory in texts by Zabel Yesayan. Syracuse University Honors Program Capstone Projects. 1064. https://surface.syr.edu/honors_capstone/1064
4. Ekmekçioğlu L and Bilal M (2006) Bir Adalet Feryadı: Osmanlı'dan Türkiye'ye Beş Ermeni Feminist Yazar (1862–1933). İstanbul: Aras
5. Nichanian M (2010) Zabel Yesayan, woman and witness, or the truth of the mask. New Perspectives on Turkey 42 (Spring): 31–53.
6. Zabel Yesayan, istanbulkadinmuzesi.org/zabel-yesayan/?tur=Alfabetik (accessed 18 February 2014).

THERAPY WITH A FEMINIST PERSPECTIVE IN WORKING WITH GENDER-BASED AND SEXUAL VIOLENCE; DISCUSSION OVER TWO CASES

Suzan Saner
Free Psychiatrist, İstanbul

Feminist-therapy theory emerged from the women's movement's criticism of mainstream psychotherapy theories in the 1960s. Feminist therapists question mental health norms and standards that leave women stranded with conflicting expectations. With a feminist perspective, therapy is aimed at social change that will eliminate inequalities, not women's adaptation to a world where inequalities are normalized. Helping women adjust to their unhappy home lives goes against the goal of feminist therapy.

Normative thought patterns about gender inequality can make it difficult for women to understand how they are oppressed. Feminist therapy encourages women to continually move towards equality and justice rather than being stuck in restrictive social and cultural stereotypes. Ethics and activism are central to feminist therapy.

The primary source of information for feminist therapists is the experiences of women. Establishing an egalitarian relationship between the therapist and the client is a model for women to establish more equal relations with others, in contrast to the traditional passive dependent role of women. The goal of feminist therapy is the empowerment of women and the treatment plan is based on supporting the woman's strengths such as resilience and flexibility from the very beginning. While taking a history, it is important not to focus only on problem areas, but also to collect information and data about their success and resistance experiences. Against the view that women's pathological behaviors are the product of a disorder in the individual, they are considered coping skills to survive in an oppressive world. While the damage done to women by living in a sexist society is always taken into account, the ways in which women gain power and control, use power in their relationships, and the consequences of this are reviewed together. All individual differences and different experiences are valuable, they are all unique, but at the same time, everyone's story is common. With a non-victim-blaming approach, women's feelings such as guilt, shame and anger are handled in a new framework and restructured by avoiding sexist prejudices and generalizations.

In this presentation, two case examples in which different layers of gender-based violence and sexual violence are revealed will be handled and discussed with an approach in line with the tenets of feminist therapy. Considering the sociocultural and political context while working in the field of violence and women's mental health will be promoted as an ethical responsibility. It will be detailed that traditional therapist behaviors that accept and maintain stereotyped gender roles serve to keep women oppressed and "in their place".

References

1. Ballou M, Hill M, West C Editors (2008) Feminist Therapy: Theory and Practice. Springer, New York.
2. Purple Roof & WAVE (2021) Report on promising practices in establishing and providing specialist support services for women who have experienced sexual violence.
3. Walker L (1992) Women as therapists: A multitheoretical casebook. Cantor, DW, Editor. Aronson, New Jersey. s. 78-95.

CELİLE HANIM: A WOMAN WHO GIVES BIRTH TO FREEDOM WHILE LIVING IN CAPTIVITY

Rengin Güvenç, Psychiatrist
Balıklı Greek Hospital, İstanbul, Türkiye

Gender equality is guaranteed by national and international regulations, there is no country in the world where gender equality can be fully achieved. However, this disparity is more pronounced in some regions. One of these 'less equal' countries is Turkey. Our country ranks 133rd among 156 countries in terms of gender equality and the status of women (1). Unfortunately, we all worry that we will fall further below this ranking in the coming period, with Turkey's withdrawal from the Istanbul contract this year. Gender inequality is an important reason for the higher prevalence of mental disorders in women. The World Health Organization associates the higher incidence of mental illnesses in women with exposure to stress and risk factors rather than a biologically based predisposition (2). WHO also underlines that clinicians dealing with female mental health patients should be trained in trauma (2).

In the panel, I will tell the life story of Ayşe Celile Hanım, one of Turkey's first female painters. There are several reasons why I chose Ayşe Celile Hanım as a women activist. She had a life full of struggle as well as glamorous. She lived as a court noble in the last periods of the Ottoman Empire and the first establishment years of Turkey. Due to her position, most of the difficulties in her life were not class-based conflicts, but gender inequality-based conflicts. At a time when the political atmosphere was constantly changing, she tried to take part in politics. There is a strong tendency to associate the concept of honor with women, female sexuality and the control of women(3). Celile Hanım tried to experience the feeling of love that she had experienced for the first time in her life against the criticism of "honor" from her surroundings. During the period, even the women's demand for divorce was not welcomed, she was able to go after her lover Yahya Kemal by divorcing her husband, but she was left by her lover with the same imposition of honor. Celile Hanım was able to turn this challenging situation into productivity by going to Paris and focusing on painting. The understanding that the mother was responsible for all kinds of disruptions in the development of the child, from the feeding of the child to the friendships relations, which continues even now, was also prevalent at that time (4). Celile Hanım managed to carry the responsibility of raising a 'traitor'. She had always been a supporter of Nazım Hikmet in his struggle until the end of her life. Even at the age of 80, she started a petition campaign with a banner she opened on the Galata Bridge for the death fast that Nazım started in the twelfth year of his twenty-eight-year prison life.

In this presentation, the fact that gender inequality is a concept that continues throughout history and affects every class will try to be discussed through a life story.

References

1. World Economic Forum (2021). Global Gender Gap Report 2021
2. World Health Organization (2002). World report on violence and health: Summary. Geneva
3. Birleşmiş Milletler Nüfus Fonu (2005) Türkiyenin Namus Cinayetlerinin Dinamikleri Eylem Programı için Önerile Sonuç Raporu. Birleşmiş Milletler Kalkınma Programı, yay haz:Kardam Filiz, Ankara, Nüfus Bilim Dergisi, s.88.
4. Kadınların Yaşamı ve Kadın Ruh Sağlığı, Nisan 2013, Ankara, Türkiye Psikiyatri Derneği Yayınları

ELEKTROKONVULZİF TEDAVİYE YANITIN ÖNGÖRÜCÜLERİ

Dr. Mehmet Çağdaş Eker

Bipolar Bozukluk (BPB) psikiyatri alanının en önde gelen ve yaşamı tehdit eden hastalıklarındandır (Kessler ve diğerleri, 2014; Merikangas ve diğerleri, 2011). Bu rahatsızlıkta gözlenen tedaviye direnç veya yaşamsal tehlike (intihar riski, yeme-içme reddi, katatoni vb.) durumlarında Elektro-konvülzif Tedavi (EKT) önemli bir seçenek olarak kabul edilmektedir (Taylor, 2007). Yaklaşık 90 yıldır kullanılan bu tedavi yöntemi aynı zamanda çeşitli eleştirilere de konu olmuş ve gereğinden fazla kullanıldığı yönünde kaygılar dile getirilmiştir. Tedavi yanıtlarının öngörülebilmesi gereksiz kullanımın önüne geçebileceğinden hastalar EKT'nin getireceği risklere karşı korunmuş olacaktır. Ayrıca işe yaraması beklenen hastalar için de tedavi şansını artıracaktır. Günümüzde hangi hastaların tedaviye daha iyi yanıt verebileceğine ilişkin veriler giderek artmaktadır. Uzun süredir bilinen klinik özelliklerin yanında son dönemde beyin görüntüleme çalışmalarında EKT'ye yanıt verebilecek hastalara ilişkin bulgular elde edilmiştir. Bu konuşmada EKT'ye yanıtı belirleyebilecek klinik, demografik, elektro-fizyolojik ve beyin görüntüleme çalışmalarından derlenen sonuçlar sunularak tartışılacaktır.

Bipolar disorder is one of the most prominent and life threatening illnesses of psychiatry (Kessler et al, 2014; Merikangas et al, 2011). Electroconvulsive therapy (ECT) is considered as a primer option in treatment resistant cases and life threatening conditions (e.g. suicide risk, negativism, catatonia) (Taylor, 2007). In its 90 years of treatment history there is still criticism on its application. The prediction of treatment response would prevent unneccesary use and thus protect patients from the adverse events of ECT. It is also likely that the prediction of treatment response will lead to the preference of ECT and increase the chance of recovery for the individual patient. The data on prediction of ECT response is accumulating. The clinical features that are related to ECT response are established in the last decades. Recently, brain imaging studies revealed features associated with good ECT response. In this panel, we will discuss the data from clinical, demographic, electrophysiologic and brain imaging studies regarding ECT response prediction.

References

1. Kessler, R. C., de Jonge, P., Shahly, V., van Loo, H. M., Wang, P. S.-E. ve Wilcox, M. A. (2014). Epidemiology of depression. Handbook of depression, 3rd ed içinde (ss. 7-24). New York: The Guilford Press.
2. Merikangas, K. R., Jin, R., He, J. P., Kessler, R. C., Lee, S., Sampson, N. A., … Zarkov, Z. (2011). Prevalence and correlates of bipolar spectrum disorder in the World Mental Health Survey Initiative. Archives of General Psychiatry. doi:10.1001/archgenpsychiatry.2011.12
3. Taylor, S. (2007). Electroconvulsive therapy: A review of history, patient selection, technique, and medication management. Southern Medical Journal, 100(5), 494-498. doi:10.1097/SMJ.0b013e318038fce0

WHO IS SUICIDE FOR? WHAT IS IT FOR? SUICIDE FROM DURKHEIM'S PERSPECTIVE

Deniz Deniz Özturan, Assist. Prof. M.D.

Department of Psychiatry, Faculty of Medicine, Ordu University, Ordu, Turkey

According to the World Health Organization (WHO), over one million people die by suicide which means that every minute two or more people die because of suicide. Sociological approach to the phenomenon of suicides was initiated by Émile Durkheim .Le Suicide: Étude de sociologie is a book written by him in 1897. It was the first methodological study of a social fact in the context of society. According to Durkheim, suicide is not an individual act nor a personal action. Émile Durkheim's (1897/1951) study of suicide, the disciplines' greatest contribution to suicidology. The definition of suicide is: "The term suicide is applied to all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result." for him.

Durkheim classified suicides as egoistic, altruistic, fatalistic anomic. When a man feels isolated that he has no place in the society he destroys himself, it is egoistic suicide. This type of suicide occurs when individuals and the group are too close and intimate, it is classifed as altruistic suicide. According to Paiva anomic suicide, as defined by Durkheim, "results from a lack of an absence or loosening of social norms". An excess of rules could lead to fatalistic suicide when, through over-regulation, individuals would lose control over themselves.

Durkheim's theory of social disintegration may be useful in the assessment of suicide risk when designing suicide prevention programs and for mental health clinicians in their practice.

For this presentation , the main objective was to discuss suicide from the perspective of Durkheim.

References

1. Durkheim E. İntihar (Toplumsal bir inceleme), çev. Özer Ozankaya, İstanbul, Cem Yay. 2002.
2. Paiva A. Durkheim. Sociological thought. A didactic introduction to classical theories. Lisboa: PACTOR–Edições de Ciências Sociais, Forenses e da Educação; 2014. 371 p.
3. Kołodziej-Sarzyńska, M., Majewska, M., Juchnowicz, D., & Karakuła-Juchnowicz, H. (2019). Risk factors of suicide with reference to the theory of social integration by Émile Durkheim. Psychiatr Pol, 865-881.
4. World Health Organization. 2017. Global Health Observatory data. http://www.who.int/gho/mental_health/en/ (retrieved: 4.11.2017).

EVALUATION OF SUICIDE WITHIN DIFFERENT OCCUPATIONAL GROUPS

Dr. Elif Aktan Mutlu
Bursa City Hospital Psychiatric Clinic

Work-related suicides are recognized as a public health problem by many countries. International Labor Organization, on the other hand, reports that individuals of working age compose the majority of suicides. Laws have been established on the necessity of recognizing and documenting these suicides. Moreover, there has been a consensus on examining the employer's liability and investigating the link between suicide and work, even if it takes place outside the workplace. However, the number of countries that do not have such laws shouldn't be underestimated (1). There are some risk factors regarding work-related suicides, acknowledging these factors properly will also make it easier to take precautions. Some of these factors are being exposed to events leading to post-traumatic stress disorder, working in environments with firearms, working in environments with a lot of medical drugs and chemicals, and excessive daily stress in business life. Furthermore, doctors, pharmacists, chemists, police officers, farmers, especially female doctors/ nurses/ military personnel being more at risk due to "family-career" conflict are among the vulnerable groups in terms of work-related suicides. In addition, lack of job autonomy and diversity, existence of work-family conflict, dissatisfaction with job, pointless and unsatisfying work, lack of support from seniors and co-workers, excessive job demand, overtime pressure, effort-reward imbalance, absence of job security, working temporary jobs, economic uncertainty, fear of job loss, mismanagement and injustice, harassment, bullying, extreme discipline, trauma, accessibility to suicide tools, work-related tinnitus, ache and distress are some of risk factors that increase work-related suicides (2).

In order to prevent work-related suicides in the workplace, initially, workplaces should develop a policy on this issue. Indications that occur in individuals who are considering to commit suicide should be recognized and afterwards, these indications should be responded. Following all these are achieved, protection measures should be put into place. It is necessary to take protective measures such as increasing the employee's control over the work, identifying and eliminating or reducing the stressors that may impair the mental health of the work, creating a free work environment where work problems can be discussed, determining the sources within or outside the workplace where employees can get help in case of suicide or mental health problems, raising awareness of employees by providing trainings and ensuring the regular observation of the occupations at risk of suicide (3).

In conclusion, work-related suicides are complex incidents which arise from the working conditions in the workplace that become more and more difficult merging with the problems in the social environment. Stressors such as nepotism, irregular working hours, not having a voice in the workplace, social and financial insecurity are some of the facilitating factors for work-related suicides. Health and safety policies must be developed and implemented in workplaces to prevent suicides.

References

1. Epik, M.T. Psikososyal Bir Risk Olarak İşyeri İntiharı. Sosyal ve Beşeri Bilimler Dergisi, 12(2), 175-197.
2. Elbir, N. İş ve Sosyal Güvenlik Hukukunda İşe Bağlı Stres Kavramı. Marmara Üniversitesi Hukuk Fakültesi Hukuk Araştırmaları Dergisi, 27(1), 798-824.
3. Milner, A., Page, K., Spencer-Thomas, S., & LaMontagne, A.D. (2014). Workplace suicide prevention: a systematic review of published and unpublished activities. Health Promotion International, 30(1), 29-37.

DEATH IS JUST A CLICK AWAY: SOCIAL MEDIA AND SUICIDE

Spc. MD Aslı Kayacan

Bolu İzzet Baysal Mental Health and Diseases Hospital

Suicide is the most common reason of preventable death across the world and is an important public health problem. Social media is a platform where individuals can share their personal information with other users in various formats such as text, images or videos providing social interaction. Social media via internet has been rapidly spreading the technology which has the possibility to affect human behavior in many aspects. İnternet and social media is an important factor for possible suicidal behavior , which is a well-known public health problem. İt is known that some information accessed via internet can encourage or facilitate suicidal behavior. Some users may find different tips about suicidal methods on internet. In this respect, examining the relationship between suicide and social media is important for both in understanding the dynamics of suicide and in preventing suicide. It is known that inappropriate sharing of suicide events in the media increases similar suicide rates(1)

On the other hand it is easy to access information and support systems that can be preventive from suicide via internet. İt might be specuated that use of social media and mobile Technologies is going to increase in this context. Research in this area is in early stage of development because of both the difficulties of focusing the subject specifically, d,ff,culties in prediction of suicide risk(2).

In this presentation possible effects of internet and social media usage on suicidal behavior , current researches regarding internet and social media usage on suicidal behavior , possible prevention of suicidal behavior with the help of internet and possible future trends in this area have been discussed.

References

1. Bal NB, Baskak N. The effect of internet and social media on suicidal behavior. In: İntiharı Anlama ve Müdahale, Temel Kitap. 2019. p. 424–32.
2. Luxton DD, June JD, Fairall JM. Social media and suicide: A public health perspective. Am J Public Health [Internet]. 2012 May 12 [cited 2022 May 8];102(SUPPL. 2). Available from: https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2011.300608
3. International, 30(1), 29-37.

WHAT IS OUR APPROACH? WHAT DO WE SAY? SUICIDE AND STIGMA

Seçil Soylu, M.D.
Private Psychiatrist, Ürgüp, Nevşehir

Suicide is a preventable leading cause of death in the US. According to the WHO, the statistics of suicide-related deaths are even more alarming in low and middle-income countries accounting for 75% of all such deaths. (1) According to Turkish Statistical Institute (TURKSTAT/TÜİK) data, 3161 people died by suicide in Turkey in 2018. (2)

Stigmatization is the negative evaluation of a person or group as defective or discredited based on characteristics such as mental illness, ethnic group, drug abuse, or physical disability. Suicide has been steeped in stigma for centuries, and there are vestigial remnants of it to this day, mostly perceived by suicide loss survivors and suicide attempt survivors. In the past, customs such as the mutilation of suicide corpses, burials outside church cemeteries, confiscation of the suicide's family property, and the excommunication of these families from the community, fueled the stigmatization of suicide. The first signs of change in survivor stigmatization came in the 18th century when legal, religious, and social systems began to reduce the use of punishment of survivors. In the 20th century, suicide began to be viewed as a complex set of physical, psychological, and social issues. Yet centuries of social stigma have not been relieved. (3)

Various scales have been developed for the assessment of suicidal stigma, such as the Stigma of Suicide Attempt (STOSA) Scale, the Stigma of Suicide and Suicide Survivor Scale (STOSASS), and the Stigma of Suicide Scale (SOSS). (4)

The fact that the usage of social media has been exponentially increasing with technological advancements in recent years and that people can express their opinions openly and anonymously directs us to a new resource to investigate the attitudes of the society toward mental illnesses and suicide. In a few studies, which analyzed the surveys and user comments shared on social media platforms such as Facebook, Twitter and Reddit, important data on attitudes towards suicide were obtained. (5)

In this presentation, it is aimed to summarize the evolutionary process of suicide and stigma from past to present and to discuss the importance of social media data for future studies in the evaluation of suicide stigma.

References

1. Kavuluru R et al. Classification of helpful comments on online suicide watch forums. Proceedings of the 7th ACM International Conference on Bioinformatics, Computational Biology, and Health Informatics; BCB '16
2. TUIK, Turkish Statistical Institute. Death Statistics,2018 (June,2019). https://data.tuik.gov.tr/Bulten/Index?p=Olum-Istatistikleri-2018-30701
3. Cvinar, J. (2005). Do suicide survivors suffer social stigma: A review of the literature. Perspectives in Psychiatric Care, 41(1), 14-21.
4. Scocco P, Castriotta C, Toffol E, Preti A. Stigma of Suicide Attempt (STOSA) Scale and Stigma of Suicide and Suicide Survivor (STOSASS) Scale: Two New Assessment Tools. Psychiatry Res 2012;200:872–8.
5. Nathan NA. Suicide, Stigma, and Utilizing Social Media Platforms to Gauge Public Perceptions. Front Psychiatry, 2019; 10: 947.

THE COURSE WILL PROVIDE THE KNOWLEDGE AND RESEARCH RESULTS ABOUT A RECENTLY INTERESTED DISORDER OR SYNDROME; MISOPHONIA. IT WILL FOCUS ON MISOPHONIA TOPIC ASSESSING THROUGH ITS DEFINITION, PHENOMENOLOGY, DIAGNOSIS, EPIDEMIOLOGY, AND CLINICAL PICTURE, ITS CONSEQUENCES AND TREATMENT.

Gökhan Öz

In my part; i will try to describe misophonia through these questions:

What is/is not misophonia?

Misophonia is a disorder of decreased tolerance to specific sounds or stimuli associated with such sounds. (1).Misophonia is characterised by excessive discomfort and annoyance in response to sounds that do not annoy most people, as well as significant levels of anger, disgust or distress upon exposure to such sounds. Misophonic sounds (triggers) are most commonly those made by other people, such as lip smacking, eating, chewing, snoring or breathing. Sounds not originating directly from other people, such as a fork scratching a plate, a ticking clock or dripping water, can also be misophonic. Although dislike of certain sounds is common in the general population, misophonia is just annoyance frome some loud sounds or higher sensitivity to disrespectness. People often experience significant social impairment at home, work, school and in social settings.

What is the prevalance of misophonia?

I will answer this question with our and other research findings (2). Based on our proposed diagnostic criteria, we examined the prevalence of misophonia and its relationship with clinical and demographic variables in a large representative population sample and found 12.8% ratio of misophonia in the general population.

What is the appearance of misophonia?

There will be presentation of case examples and clinical experiences to describe misophonias forms.

What is the evaluation methods and clinical scales of misophonia?

It will be discussed of exiting lately developed questionairres and scales and our semi-structured misophonia assesment battery; Misophonia Interview Schedule (MIS) will be presented (3)

References

1. Swedo SE, Baguley DM,Denys D, Dixon LJ, Erfanian M, Fioretti A, Jastreboff PJ, Kumar S, Rosenthal MZ, Rouw R, Schiller D, Simner J, Storch EA, Taylor S, Werff KRV, Altimus CM and Raver SM (2022) Consensus Definition of Misophonia: A Delphi Study. Front. Neurosci. 16:841816.
2. Kılıç, C., Öz, G., Burcu, K., Lu, A., and Aksoy Background, S. (2021). The prevalence and characteristics of misophonia in Ankara, Turkey: populationbased study. BJPsych Open 7, 1–6. doi: 10.1192/BJO.2021.978
3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8358974/ supplementart materials S2056472421009789sup001.docx.

THE UNSEEN

Hande Gazey

According to WHO, sexual violence is defined as "any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting" [1]. Studies suggest that between %13 and %25 of women and up to %7 of men experience sexual assault in their lives [2] and sexual assault is associated with increased risk of mental disorders such as anxiety, depression, substance use disorders and post-traumatic stress disorder, however, despite these symptoms survivors seek mental health services at low rates. The low rates of mnetal health service seeking do not mean that these survivors never go to mental health professionals, but it may indicate that the mental health system and individual professionals may not identify victimization in clients presenting for treatment [3]. Factors that are related to missing out might be the importance of sexuality in society and social judgements. The social culture, that mental health professional lives in, might be marginalizing survivors in terms of gender, age, race, culture, language, sexual orientation, disability and promoting rape myths. Thus in additon to the social culture, the educational background and professional experience of the psychiatrist might affect the identification and examination of sexual traumatization history. Another factor that should be taken into consideration is the secondary trauma issues of the mental health professional. After all healthcare system with short examination periods, inappropriate environment and so fort hare influencing factors for psychiatrists identifying the clinical history of the patient. Against these barriers a feminist perspective that recognizes and examines the gendered nature of the sexual assault experience and its aftermath, including cultural and societal causes of rape, is important in mental health services [3] and mental helath professionals' education. The education and supervision of mental health professionals should give spesific attention to multiple interacting dimensions of gender, race, social class and experiences of survivors.

References

1. Organization, W.H., Violence against women: Intimate partner and sexual violence against women: Intimate partner and sexual violence have serious short-and long-term physical, mental and sexual and reproductive health problems for survivors: Fact sheet. 2014, World Health Organization.
2. Elliott, D.M., D.S. Mok, and J. Briere, Adult sexual assault: Prevalence, symptomatology, and sex differences in the general population. Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies, 2004. 17(3): p. 203-211.
3. Ullman, S.E., Mental health services seeking in sexual assault victims. Women & Therapy, 2007. 30(1-2): p. 61-84.

MISDIAGNOSIS

İrem Ekmekci Ertek

Hypersexual behavior is a concept that has not been clarified yet despite much debate, is still not included in any diagnostic classifications, but is also frequently encountered in the clinical practice. In clinical settings, increased sexual urges and related behaviors may be seen as a component of various psychiatric disorders, such as bipolar affective disorder, personality disorders, and complex PTSD. In some clinical cases, it is difficult to differentiate excessive involvement of sexual activities and increased libido as a symptom of other psychiatric conditions or as hypersexuality disorder itself, or as a non-pathological condition at all. During manic and hypomanic episodes of bipolar affective disorder, hypersexuality is a well-known symptom. These symptoms can be sometimes disruptive and difficult to manage. However, hypersexuality is not conceptualized clearly in bipolar affective disorder. It could be argued that it is dependent on the sexual norms of the culture that patients live in. The relationship between hypersexuality and personality disorders is complicated. Like many others in psychiatry, these two conditions do not have clear boundaries between normal and pathology and they have stereotypes. Also, hypersexuality disorder and some personality disorders, especially cluster B personality disorders, have some similar clinical features that can be confusing, like inability to control their impulses, emotional dysregulation, etc. The results of the studies investigating the relationship between these two conditions are conflicting. Some researchers have investigated complex PTSD and sexual behaviors but the ones that focus on PTSD and hypersexuality are low in number. Especially in the cases with childhood sexual abuse, a wide range of sexual response spectrum can be observed, from total withdrawal or dysfunction to hypersexuality. Despite this wide range of response spectrum, it is unknown why withdrawal or dysfunction has been seen in some patients and hypersexuality seen in others. It can be concluded that when a patient admits to psychiatry with hyposexual or hypersexual complaints, especially if the clinical manifestation is complex, trauma history including childhood trauma should be kept in mind. Also, it is important to examine sexual functioning in patients with PTSD, since these patients cannot easily reveal their symptoms by themselves.

References

1. Kopeykina I, Kim H-J, Khatun T, Boland J, Haeri S, Cohen LJ, et al. Hypersexuality and couple relationships in bipolar disorder: a review. Journal of affective disorders. 2016;195:1-14.
2. Fontanesi L, Marchetti D, Limoncin E, Rossi R, Nimbi FM, Mollaioli D, et al. Hypersexuality and trauma: a mediation and moderation model from psychopathology to problematic sexual behavior. Journal of Affective Disorders. 2021;281:631-7.
3. Walton MT, Cantor JM, Lykins AD. An online assessment of personality, psychological, and sexuality trait variables associated with self-reported hypersexual behavior. Archives of sexual behavior. 2017;46(3):721-33.

SEXUALITY AFTER TRAUMA AND HYPERSEXUALITY EXPERIENCES IN GAZI UNIVERSITY, DEPARTMENT OF PSYCHIATRY

Meltem Çınar Bozdağ

Hypersexual behavior is a concept that has not yet been clarified despite much debate and is still not included in any diagnostic classifications. Nevertheless, in clinical practice, it can be encountered frequently. Besides other factors, trauma is a significant aspect to be discussed in the etiology of hypersexuality. Especially in the cases of complex post-traumatic stress disorder (PTSD), sexual dysfunction can frequently be part of this clinical syndrome. There are cumulative pieces of evidence that childhood sexual abuse can play a significant role in hypersexuality cases. Hypersexuality symptoms can be manifested in many ways, especially in complex cases; identifying, diagnosing, and managing can be difficult. Additionally, there are still many questions about what is "normal" sexual behavior, and the differentiation between normal and pathological is still controversial.

While working with these patients, our clinical observations of the remarkable association between hypersexuality and PTSD led us to further analyze this issue. At Gazi University, Department of Psychiatry, we conducted a study on this topic. It was aimed to retrospectively analyze female patients with hypersexuality in terms of sociodemographic and clinical variables, as well as diagnosis and management. The results of this study will be presented with significant aspects of some cases. Shortly, our results showed that trauma is strongly associated with female hypersexuality. High rates of misdiagnosis of these patients as "bipolar affective disorder" are noteworthy, which result in extremely long delays in getting the appropriate treatment and psychotherapy that the patients need. In addition, mood stabilizers and antipsychotics including long-acting injections were unnecessary treatments with additional side effects as well as placing an extra burden on the patient and the commonwealth. In an emphatic and non-stigmatizing environment in the clinic, women can talk about their sexual life and traumas without being judged. It is also crucial to avoid assessing hypersexuality as a categorical and pathological symptom, and patients should be evaluated with their environments and socio-cultural aspects. History of trauma, especially childhood sexual abuse history must be questioned when observing signs of hypersexuality in a patient, before making a definite diagnosis of bipolar affective disorder or personality disorders.

References

1. Courtois, C. A., & Weiss, R. (2017). Early-life sexual trauma and adult-life hypersexual behavior (sex addiction) in males. Healing Sexually Betrayed Men and Boys: Treatment for Sexual Abuse, Assault, and Trauma, 147.
2. Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. Journal of traumatic stress, 5(3), 377-391.
3. Castellini, G., Rellini, A. H., Appignanesi, C., Pinucci, I., Fattorini, M., Grano, E., Fisher, A. D., Cassioli, E., Lelli, L., & Maggi, M. (2018). Deviance or normalcy? The relationship among paraphilic thoughts and behaviors, hypersexuality, and psychopathology in a sample of university students. The journal of sexual medicine, 15(9), 1322-1335.
4. Cloitre, M., Stolbach, B. C., Herman, J. L., Kolk, B. v. d., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. Journal of traumatic stress, 22(5), 399-408.

THE BECOMING AND FLOW OF THE MIND: CONNECTIVITY

Dr. Önder Küçük

Spinoza says that nature produces individualities. Lucretius explains that the motion of matter is continuous, not like a particle, but like a wave, and flows can bend endlessly. Being cannot be divided into separate parts, but is made up of continuous flows, undulations and waves. Discrete things are made up of corporeal flows moving together. They are folded over themselves in a braid of knots. Things emerge and come into being in the flux and flux of matter in motion, immanent to it. Nature consists of the motion of matter. Nature has severed its ties with its eternal essences. From Plato to Hegel, woman is subordinated to man, matter is subordinated to mind. Althusser says that matter is self-creating. The thing called mind is also a production of matter. The becoming and flow of the mind also corresponds to the becoming and flow of matter. Substance has an infinite variety of manifestations. There are intangibles (concepts, ideas, etc.) that can be considered as elements of mentality, as well as objects that can be considered as elements of spatiality. An idea, concept or thought should be regarded as “modus” as much as a corporeal object whose boundaries seem somewhat clear to us. In the decoration of reality; It has been shown as the result of different reasons such as mind and body, culture and nature, animate and inanimate, inner and outer, or self and other(s). A body has no quality or function that is not based on original (basic) relationality. In the example of the human being, Spinoza positions the ‘conatus’ in desire. But desire should not be read simply as an automaton, an impulse or an impulse for the subject. That would be to humanize Spinoza’s thought and link it to essences. Instead, ‘conatus’, with its inevitable presence, will be much better understood in the dynamic playground of conflictual relations.

References

1. Balanuye, Ç. (2020). Naturans : Yeni Bir Ontolojiye Doğru. Ayrıntı Yayınları.
2. Akal, CB., Canaslan E.(2021) Naturalizm ya da Yitirirken Doğayı Hatırlamak. Dost Kitabevi.

MEMORY OF AMNESIA

Dr. Ersin Baltacı

When we look at the history of philosophy from an ontological perspective, we see that two basic views have an important place. The first is Parmenides's view that there is no change in life, and the other is Heraclitus's statement that every day is new, everything flows. The ontological problem is not over. How can we have static information in a world where everything is changing? Are there constant elements in the flowing world? Can it be overcome by creating two separate worlds from the Platonic perspective, the world of ideas and the world of appearances? Are appearences as shadows reflections of ideas? From this perspective, the world consists of models and Demiurgos consists of flowing copies produced from these models. We have no choice but to start from the copies.

As a thinking being in the flowing world, people always seek stability in their encounters with their habits and the power to record and forget the past in their memory.

The power of thinking contributes to our ability to adapt to the world and to exist and survive from an evolutionary perspective.

On the other hand, we try to understand the world and reveal the truth through the power of thinking.

There are various ideas about understanding the truth in the history of philosophy.

Could it be that the power of thinking, which is an evolutionary breakthrough, is performing various operations on reality in the flowing world and constricting and distorting it?

Could it be that my thinking process is replacing real authenticity with a false one?

Could it be that my senses and my consciousness are merely giving me a useful simplification of reality?

Can the mind's power to categorize, create representations, homogenize, ignore differences have a structure that stabilizes reality?

Deleuze argues that in the philosophical worldview from Aristotle to Hegel, difference reduces to conceptual difference. The central point of his philosophy, which evaluates difference in terms of its relation to difference, includes criticisms of reactivity, sensori-motor habits and memory

Everything appears and disappears. There are invisible powers under the visible. Time reveals and hides affects. All the past is preserved in itself.

Here, we come across the concepts of virtual and actual. "No object is wholly actual, every actual thing is surrounded by a fog of virtual images". By protecting itself, the past envelops the actual as a virtual fog in the present.

According to Bergson, the past and the future essentially coexist in the lived present. There are no successive presents, a new present can only appear simultaneously with the passing of the old present. The now coexists with a past that includes all presents.

According to Deleuze, the past is simultaneous with the present. The whole past coexists with the new present, where it is now the past. Every actual present constitutes the whole past in its most shrunken form.

Habit and memory make life practically easier by finding unchanging constants in the flowing life, but they cover up the truth.

In this presentation, attention will be drawn to the misleading effect of habit and memory on human thinking power, and the nature of the virtual field will be discussed.

References

1. Henri Bergson, Madde ve Bellek. Çev: Işık Ergüden. Dost Kitabevi, 2. Baskı. Ankara,2015.
2. Sadık Erol Er, Gilles Deleuze'ün Fark Felsefesi:Bergson, Nietzsche ve Spinoza Okuması. Çizgi Kitabevi.Konya,2012.
3. Joe Hughes, Deleuze'den sonra Felsefe. Çev:Fahrettin Ege.Bilim ve Sosyalizm Yayınları. Ankara, 2014.
4. Gilles Deleuze, Fark ve Tekrar. Çev:Burcu Yalım ve Emre Koyuncu. Norgunk Yayınevi.2. baskı. İstanbul,2021.
5. Pascal Boyer, James V. Wertsch, Zihinde ve Kültürde Bellek.Çev: Yonca Aşçı Dalar. Türkiye İş Bankası Kültür Yayınları. 2. Baskı. İstanbul, 2021.

PSYCHOTHERAPY AS A FIELD OF ENCOUNTER

Özlem Albayrak, MD,
Psychiatrist and Psychotherapist

Deleuze is a philosopher who stood against dogmatic structure of traditional philosophy that thinks within the dynamics of identity and disparity. Deleuze creates, re-creates and distorts concepts that just like in the concept of "ontology" in philosophy, the "subject" in psychology, within a repeating and diversifying frame. As he explains in his book "Difference and Repetition", an image of thought is the fixation element of thought and life that constitutes a representation of subject and object. Therefore, our perception of life and way of thinking occur through intermediation of concepts.

Deleuze and his psychoanalyst colleague Guittari who was the co-writer of "Anti- Oedipus" argue that psychology and psychoanalysis are reductionist in the way to restrict the concept of "subjectivity" due to their structure that contains many conceptual constants such as oedipus complex. According to Deleuze and Guittari, the subject is not stable; it is constantly changing and open for experience. Therefore, subject cannot be defined over the constant of "past-defines-present". Deleuze and Guittari also posed a challenge to psychoanalysis with their Freudian and Lacanian literary criticism.

The difference among Deleuze and modern philosophers such as Foucault, Derida etc. who discovered the internal link between the form of thinking regarding ourselves & our world and the way we structure our lives, is Deleuze's determination to create a "new thought". Rather than an attempt to "discover" the nature of things or subject, he sees new opportunities for "creation". Since "concepts" can never exist by only themselves, they have constantly reproducing connections in relation to their relations with other concepts.

Ultimate goal of Deleuze is to divert the negative perception of the difference in between representation and subject-object universe, towards positive by granting it as the real reason for existence, therefore liberating the creation of "new", from being something abandoned. He opens a new area of non-thoughts for thought by thinking beyond creation of meaning and existing values. He refuses fixed categories of mind by his argument to think with-the-world rather than about-the-world. This world is plenteous, and it connects the change and creation of new to an existence that grounds solely on its own. That is how it frees the new.

So how should we interpret the encounter of the psychotherapist and the client in a psychotherapy room, in other words two "subjects" who are in "becoming" within the context of Deleuze philosophy? Is it possible to argue that during a psychotherapy process there is a creation process of subjects who think together and are affected from each other?

References

1. Gilles Deleuze, Fark ve Tekrar, çev., Norgunk Yayınları;2017
2. Gilles Deleuze, Felix Guattari, Anti-Ödipus-Kapitalizm ve Şizofreni 1, çev., Bilim ve Sosyalizm Yayınları; 2012
3. Gilles Deleuze, Anlamın Mantığı, Norgunk Yayınları;2015

ARE ADOLESCENTS WHO SELF-INJURE ALL SIMILAR OR DIFFERENT? CLINICAL ASPECTS AND TREATMENT APPROACHES

Doç. Dr. Ömer Başay

Non Suicidal Self Injury (NSSI) manifests itself in a broad spectrum of clinical appearance and severity. Some of the adolescents with NSSI maintain the behavior for a long time, tend to the act in more severe forms of the behavior such as cutting or burning themselves, and carry NSSI to adult life by integrating the behavior in the personality structuring (Klonsky et al. 2014). It has been stated that these young people use the autonomic functions of behavior more frequently, are at higher risk of suicide and have a higher rate of psychopathology. Some adolescents, on the other hand, perform the behavior specific to the period and terminate it in the advanced adolescence years. These young people, experience difficulties specific to adolescence period and use the social functions of behavior more frequently. (Klonsky and Onlino 2008, Kabukçu Basay B and Somer O 2018). It is important to distinguish the adolescents who are experimental/episodic self-injurers and those who exhibit NSSI in repetitive patterns and are more at risk of comorbid psychopathology and suicide, in order to correctly identify and distinguish young people who are really at risk, to treat them with appropriate treatment methods and to prevent inappropriate stigmatization of milder forms as well (Somer et al. 2005).

There is no single treatment option for NSSI considered as the gold standard for children and adolescents. Much of the current literature on NSSI treatment in children and adolescents has focused on cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT), psychoeducation, family therapies, and school-based interventions. Psychopharmacological treatment approaches, on the other hand, aim the treatment of mental disorders such as major depressive disorder, anxiety disorders, disruptive behavior disorders and personality disorders associated with NSSI rather than the NSSI itself. While individual psychotherapies, including CBT and DDT, and psychopharmacological agents such as selective serotonin reuptake inhibitors are significantly promising in addressing NSSI-related psychopathology, treatment approaches by addressing the underlying mechanisms that lead to NSSI in adolescents are specifically needed.

References

1. Klonsky ED, Victor SE, Saffer BY (2014) Nonsuicidal selfinjury: what we know, and what we need to know. Can J Psychiatry 59(11):565–568
2. Klonsky ED, Olino TM. (2008). Identifying clinically distinct subgroups of self-injurers among young adults: a latent class analysis. J Consult Clin Psychol 76(1):22-7
3. Kabukçu Başay B, Somer O (2018). Ergenlerde Kendine Zarar Verme Davranışı, Ergenlik Dönemi ve Ruhsal Bozukluklar, 1. Baskı, Bildik T (Ed), Ankara, Türkiye Klinikleri, s. 277-86.
4. Somer O, Bildik T, Kabukçu-Başay B, Güngör D, Başay Ö, Farmer RF (2005). Prevalence of non-suicidal self-injury and distinct groups of self-injurers in a community sample of adolescents. Soc Psychiatry Psychiatr Epidemiol 50(7):1163-71.

ALEXITHYMIA AND SUICIDAL BEHAVIOR

Dr. Doğancan sönmez

Recep Tayyip Erdogan University Faculty of Medicine, Department of Psychiatry, Rize

Globally, approximately 800,000 people die by suicide every year. Suicide is the most common cause of death for men aged 20–49 years in England and Wales. It is estimated that one person in fifteen has made a suicide attempt at some point in their life. Further to this, lifetime prevalence of suicide ideation in Europe is estimated at 5.6%. Suicide ideation has been found to be related to emotional distress, and more severe psychopathological symptoms. It has therefore been advocated that suicide ideation be considered as a key clinical outcome in its own right. It has been frequently observed that a common antecedent to suicidal thoughts and behaviours is the experience of unmanageable emotional distress. Furthermore, individuals who experience greater difficulty in regulating high levels of emotional distress are more likely to die by suicide. It has therefore been suggested that emotional dysregulation may have a considerable impact on suicidal thoughts and behaviours. Emotion dysregulation has been defined as a multidimensional construct involving maladaptive ways of responding to emotions, regardless of their intensity. Related to emotion dysregulation is the concept of alexithymia, defined as the inability to identify or express emotions. Whilst originally perceived to be a personality trait, it has since been defined as a form of emotion regulation. Since its inception in the field of psychosomatics, alexithymia has been described as having five main components: i) a difficulty in identifying one's emotions ii) a difficulty in describing self-feelings verbally iii) a reduction or incapability to experience emotions iv) an externally orientated cognitive style and v) poor capacity for fantasising or symbolic thought. One concept that may link alexithymia to suicide ideation and behaviour is depression. Indeed, depressed patients have been found to experience a greater severity of alexithymia than individuals with other psychiatric disorders. Given the close relationship between depression and suicide behaviour, it therefore seems plausible that depression might play a role in the posited relationship between alexithymia and suicidal thoughts and behaviours. Indeed it has been found that depression mediates the relationship between alexithymia and suicide risk. In addition to alexithymia impacting on suicidal thoughts and behaviours via depression, this relationship has also been found to exist independently of depression. It has been suggested that individuals with alexithymia may experience emotional information as overwhelming and confusing, which can lead to feelings of helplessnes. Furthermore, effective emotion regulation is centred on both the ability to identify one's feelings alongside the ability to respond and recover from negative emotions. Thus, for individuals with poor emotional clarity, it is more difficult to progress to effectively regulate these emotions. It is therefore hypothesised that individuals experiencing alexithymia may become motivated towards suicide ideation and behaviour due to an impaired / limited awareness of alternate ways of coping with the unnameable feelings they are experiencing (1-3). In this presentation, the relationship between alexithymia and suicidal behavior will be discussed in the light of current literature findings.

References

1. Hemming L, Taylor P, Haddock G, Shaw J, Pratt D (2019) A systematic review and meta-analysis of the association between alexithymia and suicide ideation and behaviour. Journal of Affective Disorders 254:34-48.
2. Iskric A, Ceniti AK, Bergmans Y, McInerney S, Rizvi SJ (2020) Alexithymia and self-harm: A review of nonsuicidal self-injury, suicidal ideation, and suicide attempts. Psychiatry Research 288:112920.
3. De Berardis D, Fornaro M, Orsolini L ve ark. (2017) Alexithymia and suicide risk in psychiatric disorders: A mini-review. Front Psychiatry 8:148.

NEUROCOGNITIVE DEFICIT AND SUICIDAL BEHAVIOR

Fikret Ferzan Gıynaş
Erenköy Ruh ve Sinir Hastalıkları Eğitim ve Araştırma Hastanesi

Monoaminergic system dysregulation, endophenotype and genetic models have been tried to be discovered in neurobiologically based suicide studies in recent years. Studies have attributed deficiencies in various neurocognitive abilities to suicidal phenotypes that cannot be attributed to concomitant psychopathology (Brick et al., 2019). It is known that suicide and mood disorders are clinically overlapping and even psychiatric disorders increase the risk of suicide the most.

However, some psychiatric patients do not attempt suicide. It indicates the importance of the presence of a structural predisposition or genetic predisposition for suicidal behavior and that this is independent of psychiatric illness. This fact has led to the 'suicide brain' being a field of interest lately (Aydın,2019).

In a review including several studies of neurocognitive dysfunction, Jollant et al. (2011) found that individuals with a history of suicide attempts demonstrate increased attention to negative emotional stimuli, impaired decision-making, poorer problem-solving skills, and lower verbal fluency. (Brick 2019). Some of the consistently reported neurocognitive features associated with suicide tought and behaviour include poorer declarative memory, working memory, cognitive flexibility, and more impulsivity (Richard-Devantoy and Courtet, 2016).The general hypothesis is a deficient modulation of the prefrontal cortex and other brain regions by the serotonergic system, an alteration that may possess some trait-like characteristics, including long-term stability, and would underlie clinical and cognitive traits, including a higher propensity for impulsivity or risky decision making (Richard-Devantoy and Courtet, 2016).

References

1. Brick LA, Marraccini ME, Micalizzi L, Benca-Bachman CE, Knopik VS, & Palmer RH (2019). Overlapping genetic effects between suicidal ideation and neurocognitive functioning. Journal of affective disorders, 249:104-111.
2. Aydın M, Hacımusalar Y, Hocaoğlu, Ç (2019). Neurobiology of Suicidal Behaviour. Current Approaches in Psychiatry/Psikiyatride Guncel Yaklasimlar, 11: (5).
3. Jollant F, Lawrence NL, Olie E, Guillaume S, Courtet P (2011). The suicidal mind and brain: a review of neuropsychological and neuroimaging studies. World J. Biol. Psychiatry 12 : 319–339.
4. 4) Richard-Devantoy S, Courtet P. (2016). Neurocognitive processes and decision making in suicidal behaviour. In: Kaschka, W.P., Rujescu, D. (Eds.), Biological Aspects of Suicidal Behavior. Karger Publishers 30: 88–100.

EMOTIONAL EXHAUSTION AND SUICIDAL BEHAVIOR

Seda Kiraz

Hitit University Erol Olçok Training and Research Hospital, Department of Psychiatry

Burnout syndrome, which was first put forward by New York psychotherapist Herbert Freudenberger in the 1970s, has been described with symptoms of emotional exhaustion, loss of motivation and decreased commitment. According to Maslach, burnout syndrome is characterized by three distinct traits: emotional exhaustion, depersonalization, and a lack of personal accomplishment (Wray CA and Jarrett 2019). Emotional exhaustion is when a person feels emotionally overloaded and exhausted due to her/his work and is the most important determinant of burnout. Emotional burnout may manifest itself with symptoms such as a chronic state of irritability, quick temper, impatience, low self-esteem, worthlessness, difficulties in cognitive skills, disappointment, depressed mood, anxiety, restlessness and hopelessness. While fatigue and work-related stress are seen in almost all occupational groups, burnout is defined for risky occupations (nursing, doctor, police etc.) that serve more people. Many studies have found that the risk of suicide is associated with symptoms of depression, high levels of emotional exhaustion, depersonalization and low personal achievement. Emotional exhaustion is thought to be one of the important reasons why the risk of suicide is higher in risky occupational groups such as healthcare professionals, compared to other occupational groups and the general population (Andela 2021). It is possible to say that especially the emotional exhaustion dimension of burnout reduces job satisfaction and increases suicidal ideation. For this reason, it is very important to determine the satisfaction levels of employees with their work conditions and to determine their relationship with burnout. Many interventions such as reducing the stigma against meeting with a mental health professional, including burnout syndrome in classifications as a diagnosis, teaching employees about coping with stress, establishing good relations at work and improving working conditions will reduce the symptoms of burnout. Finding effective intervention strategies to reduce symptoms of emotional exhaustion can prevent harmful consequences, including the risk of suicide (Edwards DL and Wilkerson 2020).

References

1. Wray CA & Jarrett SB (2019) The relationship between burnout and suicidal ideations among Jamaican police officers. International Journal of Police Science & Management 21(3): 181-189.
2. 2. Andela M (2021) Work-related stressors and suicidal ideation: The mediating role of burnout. J Workplace Behav Health 36(2): 125-145.
3. 3. Edwards DL & Wilkerson ND (2020) Emotional exhaustion and its relationship with suicide risk in emergency responders. Psychiatry Research 293: 113379.

SUICIDE AND STIGMA

Buket Koparal

The onset of mental health problems usually occurs during adolescence (2). Unfortunately, most cases of mental health problems, such as depression, are often unrecognized, misdiagnosed, or un- treated (1,2). Consequently, one of the most common effects of the nontreatment or late detection of mental health problems is the increased risk of suicide (3). Stigma towards mental illness and towards suicidality in particular is considered one of the most common barriers for seeking professional psychological help (4). In addition, knowledge about suicide is inadequate among youth and has not been widely explored. Therefore, stigma and lack of knowledge on suicide may limit the development and implementation of effective suicide prevention strategies and healthcare interventions at the individual and community levels. Stigmatizing attitudes towards suicide cause people who think about suicide to isolate themselves from the environment and disconnect them from life, their relationships with family and friends, and society. This stigma makes the process difficult for those who have suicidal tendencies as well as those who have lost a loved one as a result of suicide. There is insufficient information about suicide, especially among young people, and there are not enough studies on this subject. In a study conducted by Öztürk et al. in 2018 with university students, it was found that the level of knowledge about suicide is low, and the level of knowledge of those who had a previous psychiatric diagnosis was higher (5).

In a number of studies, attitudes towards suicide among mental health workers were found to be positive (6). On the other hand, in studies examining the attitudes of medical school students towards suicide, it was found that some students had a rejecting attitude and evaluated suicide as a cowardly attitude (7).

While there are different reasons for the stigma towards suicide, one of the important reasons is misunderstandings about the cause of suicide. A suicide attempt should be considered as seeking help. However, after a suicide attempt, they are often stigmatized as a desire for attention. In a study by Luoma et al., it was determined that 45% of those who committed suicide consulted a healthcare professional in the month before the suicide, and only % 32 went to a psychiatrist within 1 year before the suicide (8).

Evidence shows that increasing mental health literacy and reducing stigma towards suicidal people are associated with more positive attitudes towards seeking professional psychological help for mental health problems. Stigma can be reduced by increasing education on suicide and mental health. Therefore, the use of mental health services can be improved and suicides prevented.

References

1. World Health Organization. (2019). Suicide. Retrieved from: https:// www.who.int/news-room/fact-sheets/detail/suicide
2. Rockett, I. R., Regier, M. D., Kapusta, N. D., Coben, J. H., Miller, T. R., Hanzlick, R. L., et al. (2012). Leading causes of unintentional and intentional injury mortality: United States, 2000–2009. American Journal of Public Health, 102(11), e84–e92
3. Arafat, S. Y., Al Mamun, M. A., & Uddin, M. S. (2019). Depression literacy among first-year university students: A cross-sectional study in Bangladesh. Global Psychiatry, 2(1), 31–36.
4. Keller, S., McNeill, V., Honea, J., & Paulson Miller, L. (2019). A look at culture and stigma of suicide: Textual analysis of community theatre performances. International Journal of Environmental Research and Public Health, 16(3), 352.
5. Öztürk, A., & Akin, S., (2018). Evaluation of knowledge level about suicide and stigmatizing attitudes in university students toward people who commit suicide. Journal of Psychiatric Nursing, 9(2), 96-104.
6. Gagnon J, Hasking PA. Australian psychologists' attitudes towards suicide and self-harm. Aust J Psychol 2012;64:75–82.
7. Eskin M, Voracek M, Stieger S, Altinyazar V. A cross-cultural investigation of suicidal behavior and attitudes in Austrian and Turkish medical students. Soc Psychiatry Psychiatr Epidemiol 2011;46:813–23.
8. Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry 2002;159:909–16.

THERAPY WITH A FEMINIST PERSPECTIVE IN WORKING WITH GENDER-BASED AND SEXUAL VIOLENCE; DISCUSSION OVER TWO CASES

Ayşe Devrim Başterzi, Assoc. Prof.,
Psychiatrist, İstanbul

Mainstream theories in psychiatry have ignored or underestimated important social, economic, and structural influences on people especially last 30 years and focus on individual development of disorders biological, neurological, and genetic factors. During COVID-19 pandemics mental health experts could not continue to ignore/minimize the negative impacts of social factors such as deep-rooted structural inequalities and personal impacts such as social isolation, bereavement, sickness, uncertainty, impoverishment, and poor access to health care (Herrman et al. 2022) The pandemic has caused a breach in the hegemony of biopsychiatric discourse.

Contemporary feminist perspective is not only concerned with women issue. It focuses on oppression and unequal power relations in everyday life. Third wave feminism works to incorporate an intersectional understanding of identity by including race, sexual orientation, gender identity, ability, class, and age into its politics. All these inequalities related with depression, anxiety disorders and other mental health problems. Feminists have critiqued traditional psychiatric taxonomy and treatment guidelines for more than four decades (Cosgrove and Wheeler 2013). Treatment of mental disorders cannot be limited to pharmacotherapy or short-termed therapy sessions as much as paid by insurance companies. Psychotherapy is an effective treatment option especially who injured by socioeconomical inequalities.

Since the 1960s, the feminist perspective has influenced contemporary psychotherapy theory and practice. Increased attention to the therapy relationship, especially in matters of power and communication between client and therapist, reflects very clearly the impact of feminist therapy. Holding clients' stories (their understanding of their experiences) as valid, and indeed central to therapy, is a heritage of feminist therapy. Domestic violence, childhood sexual abuse, rape, and sexual harassment are more frequently recognized and reported last 40 years. Informed consent and prohibitions against therapist usury—whether economic, ego-gratifying, or sexual in nature—are further changes in therapy practice wrought through feminist therapy analysis and action. Another major contribution is the influence of the sociopolitical context on the individual. Models, theories, and orientations, including multicultural, constructivist, narrative, liberation, and ecological, have been influenced by this awareness and the need to change social policy and embedded values (Ballou et al. 2008).

In this workshop, the psychotherapy process of two women who were exposed to gender-based violence will be discussed within the framework of feminist therapy.

References

1. Ballou M, Hill M, West C Editors (2008) Feminist Therapy: Theory and Practice. Springer, New York.
2. Herrman H, Patel V, Kieling C, Berk M, et al. (2022) Time for united action on depression: a Lancet-World Psychiatric Association Commission. Lancet. 5;399(10328):957-1022. doi: 10.1016/S0140-6736(21)02141-3.
3. Cosgrove L, Wheeler EE (2013). Industry's colonization of psychiatry: Ethical and practical implications of financial conflicts of interest in the DSM-5. Feminism & Psychology, 23(1), 93–106. doi:10.1177/0959353512467972

MADNESS AND LITERATURE

Burhanettin Kaya

As a consequence of the historical progression and evolvement of the psychiatry field, the boundaries between normality and abnormality, the varying forms of abnormality and their psychological categorization grow to be more problematic. Madness is also a concept that grows to be more problematic as it is incidentally associated with marginalization and labelling, or as being superior and extraordinary. In this sense, Freud comes forward as he specifically examines the relationship between literature and madness while developing his theoretical framework. He even mentions that literary men saw many things before a psychiatrist does. In fact, the modern history of literature-Madness research appears especially with psychoanalysis and psychiatry, while theoretical debates of literature and Madness continue since Ancient Greece.

Many theoretical studies, prominently Foucault's studies on the History of Madness, have contributed greatly to the debate that is still growing with new questions. The fact that the relationship between madness and literature is the of interest of both mental health professionals and literature academicians, is related to this debate. The relationship between madness and creativity has also been a subject that has been thought about and discussed, especially in relation to the psychological histories of some artists and writers.

Characters with mental pathologies, mental breakdowns, "lunatic" characters and the texts of madness written by writers that gradually become demented and develop psychotic disorders due to being near to the lunatic character, how these texts are shaped artistically and essentially is an aspect that is analysed frequently. Hence, how "madness" is built in literary texts? The story of madness, the establishment of the language of lunacy, the function of lunacy in the work, the political and social context of the period in which madness was experienced, the examination of mental health services through madness in the literary work; or the transformation of the literary work while still carrying an aesthetic value along with the changes in the author's mental health are the main areas of study in psychiatry and literature.

In this presentation, there will be an attempt to start a discussion on the relationship between madness and literature by making use of the opportunities offered by some literary works.

Resources used and recommended

1. Banu Öztürk, Didem Ardalı Büyükarman, Seval Şahin. Edebiyatın İzinde Delilik ve Edebiyat. Bağlam Yayınları, İstanbul, 2017.
2. Edebiyat ve Delilik: Türk Roman ve Öyküsünde Deliler ve Delilik. Mehmet Narlı. İz Yayıncılık, İstanbul, 2019.
3. Louis A. Sass. Delilik ve Modernizm. Alfa Yayınları, İstanbul, 2013.

CARTOON AND MADNESS

Şahabettin Çetin
Denizli Devlet Hastanesi

Morreal analyzed humor under three theoretical headings: superiority, relief, and incongruity.

Incongruity humor deconstructs reality and rebuilds it. In this respect, humorous productions are surreal. The Surrealism Manifesto speaks of a place where "life and death, the real and the imaginary, the past and the future, the expressible and the inexpressible, the sublime and the sublime are not perceived as oppositions". It is said that this place can be reached with surreal art, dreams and humor. In addition, the psychic area f the psychotic, where the boundaries of object and self-representations disappear, can be such a place. Madness and laughter have been the elements that objected and discredited the sublime, absolute and unquestionable throughout history.

Cartoon has been defined as a satirical or humorous depiction of social, political or everyday events. Truths that are difficult to express in daily life are exaggerated. Hierarchies are turned upside down by deliberately distorted body images. The strangeness of the visible and the signified is revealed in this way. In the cartoon, madness is most often depicted with a person with a funnel on his head. As in different branches of art, the role given to the insane in cartoons is variable. The most common pattern is the type of crazy as a sage who is strange, different from the general society, but points out the truth. Another is that the contrast that emerges in the relationship with people who are considered 'normal' is presented as a 'conflict'. This narrative mostly aims to cause confusion in the audience as to which is strange. Cartoon can be read as a kind of madness in daily social and political events. The cartoonist is a mad too. What they're trying to do is point out the weirdness of what's going on, mostly under the cover of comedy. Madness has been excluded from society for hundreds of years. In some periods, they were thrown out or closed in communities. In the cartoons, madness is drawn into daily life.

As the person who comes into contact with the madman the most, the 'mad doctor' is also an important object of the cartoon. The psychiatrist stereotype also repeatedly shows the incongruity in communication between the 'serious' doctor representation and the patient. In this presentation, the relationship between cartoons and madness as a type of humor, the representations of the perception of madness throughout history and the depictions of madness in cartoons will be explained.

Resources used and recommended

1. Morreall J (1983) Taking laughter seriously. Albany: State University of New York.
2. Breton A(1972) Manifestoes of surrealism. Ann Arbor :University of Michigan Press.

ART AND MENTAL ILLNESS

Deniz Deniz Özturan, Assist. Prof. M.D.
Department of Psychiatry, Faculty of Medicine, Ordu University, Ordu, Turkey

Creativity is defined as the ability to generate ideas or products that are original. Since Aristotle claimed that most poets were "openly melancholic," mental illness is closely related to artistic creation. Art is a product of human creativity. it is possible to express feelings, opinions and attitudes. Case studies of single artists with a history of serious mental disorder, such as Vincent Van Gogh , Edvard Munch, Louis Wain, Salvador Dali , are rich in descriptions of psychopathology. There are many reasons Vincent Van Gogh might have mentall illness. The ear incident was the result of Vincent's first major mental breakdown. The man who drew cats" (Louis Wain) was an important witness of the phases of schizophrenia. In 1893, Munch started his most famous and replicable work – "The Scream" Edvard Munch's quote is well known:*" I was walking along a path with two friends — the sun was setting — suddenly the sky turned blood red — I paused, feeling exhausted, and leaned on the fence — there was blood and tongues of fire above the blue–black fjord and the city — my friends walked on, and I stood there trembling with anxiety — and I sensed an infinite scream passing through nature …"*Salvador Dalí, the well-known Surrealist artist, was 'famous' for his 'craziness'.

Is it madness or genius? Salvador Dali says: "There is only one difference between a madman and me. The madman thinks he is sane. I know I am mad."

For this presentation , the main objective was to discuss madness and art.

References

1. Carson SH. (2019). Creativity and mental illness.
2. Demarin V, Roje Bedeković M, Bosnar Puretić M & Bošnjak Pašić M. (2016). Arts, brain and cognition. Psychiatria Danubina, 28(4), 343-348.
3. Sommer R & Cassandro VJ. (2000). Perceived psychopathology in a painter's work. Psychiatric quarterly, 71(2), 153-164.
4. Damiani, S., & Fusar-Poli, L. (2018). The cats of Louis Wain: a thousand ways to draw one's mind. American Journal of Psychiatry, 175(4), 315-315.
5. Murphy, C. (2009). The link between artistic creativity and psychopathology: Salvador Dalí. Personality and Individual Differences, 46(8), 765-774.

COGNITIVE COMPLAINTS AT EARLY AGE AND POTENTIAL CAUSES

N. Gamze Usta Sağlam, MD

Istanbul Erenkoy Mental and Nervous Diseases Training and Research Hospital, Department of Psychiatry

In mental health care settings, discussions on the capacity to consent primarily focus on the capability of giving consent to treatment. The capacity to consent for sexual activity remains an under-studied area that gains especially major importance within psychiatric disorders and intellectual disabilities. Individuals with mental disorders are already at risk of sexual victimization and the incompetence to consent to sex might be contributing to this situation. Mental disorders especially schizophrenic spectrum disorders and bipolar disorder might affect individuals' decision-making abilities as a result of cognitive dysfunction or psychopathological symptoms, like psychotic features, impulsivity, or hypersexuality. Additionally, there may be great differences between patients in terms of competencies in performing activities of daily live and maintaining the ability to decision-making. This diversity makes it difficult to reach the balance between autonomy and protection. In this sense, it is substantial to evaluate the patients accurately in order to protect them from possible transmission of sexually transmitted diseases, unwanted pregnancy, sexual abuse, and violence, and also in order not to restrict sexual freedom and to protect autonomy in patients capable of making informed decisions. In a study, researchers revealed that patients with schizophrenic spectrum disorders had poorer capacity to consent to sex than patients with bipolar disorder and this difference in sexual consent capacity was not related to the symptom severity but to the level of neurocognitive impairment (Mandarelli et al, 2012). Therefore, patients with cognitive dysfunctions are at higher risk for the impairment of consent to sex.

Sexual consent capacity needs to be assessed on an individual basis and where needed interventions to enhance capacity to make sexuality-related decisions should be made. In this panel discussion, the concept of sexual consent in the context of individuals with mental disorders and the factors that may affect the capacity to consent to sex will be discussed.

References

Mandarelli G, Zangaro S, Raja M, et al. (2012) Competence to Consent to Sexual Activity in Bipolar Disorder and Schizophrenic Spectrum Disorders. Arch Sex Behav 41:507–515

RISKY SEXUAL BEHAVIORS AND THEIR MANAGEMENT IN THE INPATIENT PSYCHIATRIC CLINIC

Uzm. Dr. Batuhan Ayık

**University of Health Sciences, Istanbul Erenkoy Mental Health and Neurological Diseases Training and Research Hospital*

The term risky sexual behavior includes behaviors such as having several sexual partners, increased sexual activity, unintended pregnancy and not taking necessary precautions to prevent sexually transmitted diseases. It involves negative consequence including unintended pregnancy and HIV/ AIDS or other transmitted diseases, gained due to several sexual partners, inconsistent use of condom and having sexual intercourses under infuence of alcohol. Mental illness is an independent risk factor for risky sexual behavior. Especially in young people with mental illness, risky sexual behaviors are observed at a higher rate compared to their peers. In addition, mental illnesses put people in a more vulnerable position in terms of poor sexual health. It was showen that 44 percent of patients with schizophrenia in facilities ranging from acute to chronic care and from inpatient to outpatient settings were sexually active and engaging in high-risk behavior—for example, multiple partners, unprotected sex, substance use, and sexual exchange. Sexual behavior on inpatient units is less common than in the outpatient community. Nevertheless, it can be a very cumbersome issue when it does occur. For inpatient clinics, each patient should be assessed for his or her capacity to make decisions about sexual behavior. This assessment should include a mental status examination, including the patient's level of orientation, and an assessment of the patient's level of understanding of the rules on the unit, including the repercussions of and alternatives to sexual behavior. All patients should have the opportunity to participate in sex education, including open discussions about sexuality and sexual preferences, personal body awareness, pregnancy and contraception, prevention of sexually transmitted diseases, and any other issues specific to a given individual. Inpatient psychiatry clinics should provide the opportunity to screen people at risk for sexual health problems and provide treatment and counseling that can contribute to better sexual health outcomes. In this session, we will discuss the risky sexual behaviors observed in women treated in a inpatient psychiatry clinic and the management of these behaviors.

References

1. Negash, B., Asmamewu, B., & Alemu, W. G. (2019). Risky sexual behaviors of schizophrenic patients: a single center study in Ethiopia, 2018. BMC Research Notes, 12(1), 1-6.Hospitalization of Transgender Youth in a Psychiatric Ward—Opportunities and Challenges: A Case Study. Sexes, 1(1), 32-38.
2. Ford, E., Rosenberg, M., Holsten, M., & Boudreaux, T. (2003). Managing sexual behavior on adult acute care inpatient psychiatric units. *Psychiatric Services*, *54*(3), 346-350.

SEXUAL TRAUMA IN FEMALE PSYCHIATRIC PATIENTS: LEGAL DIMENSION AND ETHICAL DILEMMAS

Dr. Diğdem Göverti

According to the World Health Organization (WHO), the definition of sexual violence is sexual crime, which is defined as "any sexual behavior, attempt, sexually explicit words, and physical, mental and social harm to a person without the consent of the person, by using pressure or in situations where his consent is not sought". It is all of the behaviors that are sexual in content and aim for sexual satisfaction, such as the use of physical force, threats, fear, cheating and deception, etc. (1). According to WHO data, it is stated that at least one out of every five women has been sexually assaulted during their lifetime. As sexual trauma induces many psychiatric diseases, women with a diagnosis of psychiatric disease are at higher risk of being exposed to sexual trauma (2). Although the majority of individuals exposed to sexual trauma are diagnosed with post-traumatic stress disorder, they can also apply with depression, anxiety disorder, eating disorders and substance use disorders. Multiple trauma increases the intensity of psychiatric symptoms (4). Patterns such as maladaptive coping mechanisms, difficulties in emotion regulation, and self-blame increase the risk of developing psychiatric illness. At the same time, the stigmatizing attitudes towards individuals with a psychiatric illness and the fault of judgment experienced by these individuals, especially during the exacerbation of the disease, may increase the risk of trauma exposure of these individuals.

Research and experience on women who receive treatment in psychiatry inpatient units and have a history of sexual trauma are limited (3). Sociocultural myths, pressure elements, legal dimensions, and some limitations of the interviewer may make it difficult to obtain a history of sexual trauma from patients. However, the inexperience of those working in this difficult field can lead to consequences such as lack of legal notifications, optimal and non-protective attitudes for the patient, and inadequacy in ethical practices. In such difficult and complex cases, teams of physicians, psychologists, social workers and nurses should communicate with other units related to the patient and make ethical, legal and protective decisions on behalf of the patient. The limitations of psychiatrists in the management of female patients with a history of sexual trauma in the inpatient psychiatry unit are open to debate.

It is aimed in this presentation to contribute to the limited data and experience due to the difficulties of the study in this field, to discuss the legal dimension and ethical dilemmas that challenge the clinician.

References

1. Krug EG, Mercy JA, Dahlberg LL, Zwi AB. The world report on violence and health. The lancet. 2002;360(9339):1083-8.
2. Khalifeh H, Moran P, Borschmann R, Dean K, Hart C, Hogg J, vd. Domestic and sexual violence against patients with severe mental illness. Psychological medicine. 2015;45(4):875-86.
3. O'Dwyer C, Tarzia L, Fernbacher S, Hegarty K. Health professionals' experiences of providing care for women survivors of sexual violence in psychiatric inpatient units. BMC health services research. 2019;19(1):1-9.
4. Vrana S, Lauterbach D. Prevalence of traumatic events and post-traumatic psychological symptoms in a nonclinical sample of college students. Journal of traumatic stress. 1994;7(2):289-302.

TRANSGENDERS WITH SEVERE MENTAL ILLNESS: DIFFICULTIES IN INPATIENT PSYCHIATRY SERVICE

Uzm. Dr. Alper Bülbül

**University of Health Sciences, Istanbul Erenkoy Mental Health and Neurological Diseases Training and Research Hospital*

Transgender is a wide term used to describe individuals whose gender identity (one's internal sense of being male, female, or of indeterminate sex) is different from their assigned sex at birth. Transgenders may be exposed to discrimination, bullying and violence in different areas of life due to their identities. Discrimination and violence that individuals are exposed cause different negative psychological consequences. Studies have shown that transgenders have a 2–3-fold risk of depression, anxiety, alcohol and substance usage, suicidal ideation, suicide attempts, and non-suicidal self-injury. High rates of mental illness, substance use, and suicidality are related to experiences of marginalization and oppression, including experiences of transphobia, violence, lack of social support, barriers to education, homelessness, and unemployment

Higher rates of mental illness among transgender individuals likely produce greater need for acute mental health care, including emergency department visits and hospitalizations.

Transgenders may also face some difficulties in accessing health services. Various barriers that prevent transgender individuals from accessing medical and mental health treatment have been identified. The health system and opportunities built on the binary gender system, health workers who have insufficient knowledge about transgender health and are insensitive about transgender needs, and discrimination in the health system can be given as an examples which cause these difficulties.Literature regarding the management of transgender youth in inpatient psychiatric units is scarce, but it appears that inpatient psychiatric units experience challenges similar to other healthcare settings

As in our hospital, many psychiatry services in our country have facilities such as beds, toilets and showers that are divided into gender-based "female" and "male". In this speech, the difficulties experienced in the inpatient psychiatry service based on the binary gender system and the practices applied in our hospital will be discussed.

References

1. Lam, J. S. H., Abramovich, A., Victor, J. C., Zaheer, J., & Kurdyak, P. (2021). Characteristics of Transgender Individuals With Emergency Department Visits and Hospitalizations for Mental Health. Psychiatric Services, appi-ps.
2. Gizunterman, A., Szczupak, M., Schechter, T., & Kohn, Y. (2020). Hospitalization of Transgender Youth in a Psychiatric Ward—Opportunities and Challenges: A Case Study. Sexes, 1(1), 32-38.
3. Torres, C. G., Renfrew, M., Kenst, K., Tan-McGrory, A., Betancourt, J. R., & López, L. (2015). Improving transgender health by building safe clinical environments that promote existing resilience: Results from a qualitative analysis of providers. BMC pediatrics, 15(1), 1-10.

ANXIETY AND DEPRESSION SYMPTOMS IN LONG COVID-19

Doç. Dr. Leman İnanç
İzmir Bakırçay Üniversitesi Psikiyatri Anabilim Dalı, İzmir

Information on the psychiatric sequelae of Covid-19 is scarce. Many neuropsychiatric symptoms have emerged with Covid-19 (Troyer et al 2020). Neuropsychiatric manifestations associated with 'long COVID' are depression, anxiety, post-traumatic stress disorder, sleep disturbances, fatigue and cognitive deficits (Efstathiou et al 2022). The most common symptoms are anxiety and depression (Mazza et al 2020). As well as the biological effect of the Covid -19 infection, fear or anxiety of contracting and dying from Covid-19 and lockdown in this process may also contribute in this. Risk factors for anxiety symptoms during and after Covid-19 include stress, gender, genetics, immune system, and psychological resilience. Intensive care unit admission for acute respiratory distress syndrome, a complication of Covid-19, may be the cause of prolonged anxiety symptoms (Uzunova et al 2021). In a study evaluating anxiety and depressive symptoms after Covid-19, anxiety and depression were found at a rate of 30.4% in people who had covid-19 and 26.1% in those who had not had it before (Klaser et al 2021). There is evidence to suggest that patients with a psychiatric history may be at higher risk of persisting and prolonged symptoms of depression. In another study, it was reported that half of the individuals after covid-19 had physical symptoms and these symptoms could lead to psychiatric disorders (Matsumoto et al 2022). In some studies is postulated that anxiety could be a long-term sequela of COVID-19 infection (Rogers et al 2020). Systemic inflammation biomarkers are found to be positively associated with scores of depression and anxiety (Mazza et al 2020). Experiencing multiple covid-19 symptoms increases symptoms of depression and anxiety in the post-illness period. A number of studies show that women are more likely to develop anxiety or depression at follow-up. Although the long-term consequences of Covid -19 are not clear, insomnia, fatigue, cognitive impairment and anxiety disorders are high in the first 6 months after infection (Badenoch et al 2022). There is a need for prospective studies assessing psychiatric symptoms in COVID-19 patients in the post-infection period.

References

1. Troyer EA, Kohn JN, Hong S (2020). Are we facing a crashing wave of neuropsychiatric sequelae of COVID-19? Neuropsychiatric symptoms and potential immunologic mechanisms. Brain Behav Immun, 87:34-39.
2. Efstathiou V, Stefanou MI, Demetriou M ve ark (2022). Long COVID and neuropsychiatric manifestations. Experimental and Therapeutic Medicine, 23(5), 1-12.
3. Mazza MG, De Lorenzo R, Conte C ve ark (2020). Anxiety and depression in COVID-19 survivors: Role of inflammatory and clinical predictors. Brain, behavior, and immunity, 89, 594-600.
4. Uzunova G, Pallanti S, Hollander E (2021). Presentation and management of anxiety in individuals with acute symptomatic or asymptomatic COVID-19 infection, and in the post-COVID-19 recovery phase. International Journal of Psychiatry in Clinical Practice, 25(2), 115-131.
5. Klaser K, Thompson EJ, Nguyen LH ve ark (2021). Anxiety and depression symptoms after COVID-19 infection: results from the COVID Symptom Study app. Journal of Neurology, Neurosurgery & Psychiatry, 92(12), 1254-1258.
6. Matsumoto K, Hamatani S, Shimizu E ve ark (2022) Impact of post-COVID conditions on mental health: a cross-sectional study in Japan and Sweden. BMC psychiatry, 22(1), 1-13.
7. Rogers JP, Chesney E, Oliver D ve ark (2020). Psychiatric and neuropsychiatric presentations associated with severe coronavirus infections: a systematic review and meta-analysis with comparison to the COVID-19 pandemic. The Lancet Psychiatry, 7(7), 611-627.
8. Badenoch JB, Rengasamy ER, Watson C ve ark (2022) Persistent neuropsychiatric symptoms

LITHIUM AS A CIRCADIAN RHYTHM REGULATOR

Ekrem Furkan Uçak
Konya City Hospital Department of Psychiatry

Bipolar disorder(BB) is a mood disorder characterized by recurrent mood periods (mania- hypomania-depression) and partial or complete recovery periods, observed in about 1-3% of the lifetime(1). The circadian rhythm is defined as a cycle involving biochemical, physiological and behavioral changes of about 24 hours, coordinated mainly by the suprachiasmatic nucleus. Growth hormone, cortisol, melotonin are known as biochemical; body temperature changes are physiological; sleep-wake cycle are known as behavioral rhythm determinants. Circadian rhythm disturbance in BB patients is considered a sleep disorder. However, studies have also shown evening chronotype, abnormal melatonin secretion and irregularity of social timelines(2). Various scales and polysomnography are frequently used methods to determine the rhythm of an individual. With the spread of wearable technology in recent years, actigraphic measurements have been used more frequently to individualize treatment(3). However, in recent years, advances in the field of psychiatric genetics have allowed the identification of genes regulating the circadian rhythm. These genes are called circadian or "CLOCK" genes. In the last few years, studies conducted taking into account the regulatory effect of lithium on the circadian rhythm have been increasing. It has been suggested that CRY1, ARTNL1, PER2 and NR1D1 genes may be associated with the response to lithium therapy(4-5). Especially considering the regulatory effect of lithium on circadian rhythm, the information acquired from research on CLOCK genes and related single nucleotide polymorphisms is exciting.

After a comprehensive review at this conference, we will discuss the effect of lithium on circadian rhythm in bipolar disorder. Clinical, neurobiological, genetic candidate biomarkers associated with the response to lithium will be presented to the attention of audience.

References

1. Pedersen CB, Mors O, Bertelsen A, Waltoft BL, Agerbo E, McGrath JJ, Mortensen PB, Eaton WW. A comprehensive nationwide study of the incidence rate and lifetime risk for treated mental disorders. JAMA Psychiatry. 2014 May;71(5):573-81.
2. Sehgal A, Mignot E. Genetics of sleep and sleep disorders. Cell. 2011;146:194–207.
3. Melo MCA, Abreu RLC, Linhares Neto VB, de Bruin PFC, de Bruin VMS. Chronotype and circadian rhythm in bipolar disorder: A systematic review. Sleep Med Rev. 2017 Aug;34:46-58.
4. Yin L, Wang J, Klein PS, andLazar MA (2006) Nuclear receptor Rev-erb alpha is acritical lithium-sensitive component of the circadian clock. Science311:1002-1005.
5. Takaesu Y. Circadian rhythm in bipolar disorder: A review of the literature. Psychiatry Clin Neurosci. 2018 Sep;72(9):673-682.

LITHIUM AS AN ANTI-INFLAMMATORY AND ANTIOXIDANT AGENT

Vefa Erbasan
Selçuk Üniversitesi Tıp Fakültesi Psikiyatri Anabilim Dalı

Several hypotheses have been proposed to achieve a better understanding of bipolar disorder (BD) pathophysiology, however, the etiology of BD is still unclear. With this, recently, inflammatory and oxidative processes have attracted attention in research on the etiology of the disease.

Studies have found a significant increament of pro-inflammatory cytokines and oxidative stress and accelerated neurodegeneration and cell death in BD (1). Two meta-analyses examining the relationship between oxidative stress and BD have found increased oxidative parameters such as lipid peroxide, thiobarbituric acid reactive substances and nitric oxide in patients with BD (2). In the light of all these findings, inflammatory and oxidative processes can be evaluated as a treatment targets.

Lithium, is a mood stabilizer that has been widely used in the treatment of bipolar disorder. Studies have found the following important functions of lithium related to the central nervous system: Neuroprotection; anti-inflammatory properties similar to standard drugs for the treatment of inflammatory conditions. Antioxidant properties are contributing to its therapeutic action and an important intracellular mechanism underlying the protective pharmacological effects seen in clinical practice in the treatment of different stress related adverse health conditions. Antiapoptotic properties, with greater neuron survival and a reduction in apoptosis mediators as well as oxidative substances, such as superoxide dismutase and hydrogen peroxide. Moreover, lithium has been shown to reduce oxidative stress, inflammation and apoptosis by causing an increase in levels of interleukin- 10 and brain derived neurotrophic factor and a decrease in levels of pro-inflammatory cytokines such as glycogen synthase kinase 3 beta (GSK- 3B) and tumor necrosis factor alpha (3). Lithium has also increased neurogenesis, axonal elongation and dendrite growth, and reduced in apoptosis and neurodegeneration by inhibiting GSK- 3B (4).

It is thought that all these effects of lithium can reverse the inflammatory, oxidative and neurodegenerative processes seen in BD.

References

1. Andreazza AC, Cassini C, Rosa AR, Leite MC, de Almeida LM, Cunha AB, et al. Serum S100B and antioxidant enzymes in bipolar patients. Journal of psychiatric research. 2007;41(6):523-9.
2. Brown NC, Andreazza AC, Young LT. An updated meta-analysis of oxidative stress markers in bipolar disorder. Psychiatry Research. 2014;218(1-2):61-8.
3. Szulc A, Wiedlocha M, Waszkiewicz N, Galińska-Skok B, Marcinowicz P, Gierus J, et al. Proton magnetic resonance spectroscopy changes after lithium treatment. Systematic review. Psychiatry Research: Neuroimaging. 2018;273:1-8.
4. Pasquali L, Busceti CL, Fulceri F, Paparelli A, Fornai F. Intracellular pathways underlying the effects of lithium. Behavioural pharmacology. 2010;21(5-6):473-92.

MEDICAL TREATMENT FOR ERECTILE DYSFUNCTION

Sinay Önen

The approval of Sildenafil in the treatment of Erectile Dysfunction (ED) in 1998 and its effectiveness in almost 70% of men with ED has increased the interest in pharmacological approaches in the treatment of sexual dysfunctions in the last 20 years. Available treatments for ED include sexual therapy, low-intensity extracorporeal shock wave therapy (Li-ESWT), oral medications (PDE-5 inhibitors), intracavernosal injections, transurethral alprostadil, vacuum erection devices, penile implants, and new treatment options such as stem cell therapy (SCT) and platelet-rich plasma (PRP) (1).

In most countries, the phosphodiesterase inhibitors are the initial form of pharmacotherapy for men with ED. The American Urological Association guidelines acknowledge that any treatment option may be used as a first-line therapy; however, phosphodiesterase type 5 inhibitors (PDE5-Is) are the most commonly suggested and used first-line treatment option. PDE5 inhibitors enhance erectile function during sexual stimulation by penetrating into smooth muscle cells and inhibiting PDE5, which is an enzyme that degrades cGMP. This increases relaxation of the smooth muscle, which dilates the corporeal sinusoids resulting in increased blood flow, allowing an erection to occur. Three such drugs, sildenafil, tadalafil, and vardenafil, are licensed for use around the world. A number of newer agents are available in a few countries (udenafil, mirodenafil) and others (avanafil, lodenafil, SLX-2101) are currently under development. It is known that PDE-5 inhibitors are especially effective in people with diabetes, hypertension and atherosclerotic vascular disease, and erectile dysfunction after prostate surgery and due to drug use. PDE5 inhibitors are effective, safe, and well-tolerated therapies for the treatment of ED (2-4).

Despite the increasing number of biological treatments in the treatment of ED in recent years, it is seen that the knowledge and experience of physicians working in the field of mental health does not show parallelism with this increase in biological approaches. The coexistence of psychogenic and organic etiological causes in many ED cases brings up the use of biological treatments as well as psychotherapeutic approaches in treatment. In this presentation, it is aimed to discuss the scientific data and clinical practice recommendations on the place, efficiency and effectiveness of drug therapies in the treatment of ED.

References

1. Raheem OA, Natale C, Dick B, Reddy AG, Yousif A, Khera M, Baum N. Novel Treatments of Erectile Dysfunction: Review of the Current Literature. Sex Med Rev. 2021 Jan;9(1):123-132.
2. Burnett AL, Nehra A, Breau RH, Culkin DJ, Faraday MM, Hakim LS, et al. Erectile dysfunction: AUA guideline. J Urol 2018; 200:633-41.
3. Kim S, Cho MC, Cho SY, Chung H, Rajasekaran MR. Novel Emerging Therapies for Erectile Dysfunction. World J Mens Health. 2021 Jan;39(1):48-64.
4. Eardley I, Donatucci C, Corbin J, El-Meliegy A, Hatzimouratidis K, McVary K, Munarriz R, Lee SW. Pharmacotherapy for erectile dysfunction. J Sex Med. 2010 Jan;7(1 Pt 2):524-40.

DRUG TREATMENTS FOR PREMATURE EJACULATION

Gülin Özdamar Ünal, Assist. Prof. M.D.

Department of Psychiatry, Faculty of Medicine, Suleyman Demirel University, Isparta, Turkey

According to epidemiological research data, premature ejaculation, which has a prevalence varying between 20-30%, is the most common sexual dysfunction in men. For long years, there was no commonly acknowledged definition of premature ejaculation. Premature ejaculation is the condition in which the penis ejaculates involuntarily with limited sexual stimulation before or just after the penis enters the vagina, and this event causes significant distress to the person. Premature ejaculation appears to have a complex etiology, which necessitates the use of multimodal treatment regimens(Castiglione 2016).

It has been hypothesized that 5-HT receptor dysfunction has a role in the pathophysiology of premature ejaculation. Antidepressants used in the off-label treatment of premature ejaculation include antidepressants such as fluoxetine, paroxetine, citalopram, fluvoxamine, sertraline, duloxetine, and clomipramine. Currently, the only antidepressant approved for the treatment of premature ejaculation is dapoxetine hydrochloride, a short-acting SSRI.

A hypersensitive reaction to penile stimulation is one of the physiological variables hypothesized to contribute to the pathophysiology of premature ejaculation. Local anesthetics such as lidocaine, benzocaine, and prilocaine are membrane-stabilizing agents that decrease synaptic transmission and neuronal hypersensitivity by blocking voltage-gated sodium channels, hence raising the ejaculatory threshold.

It has been reported that tramadol, a potent, centrally-acting opioid-based analgesic, alpha-1 blockers such as tamsulosin, silodosin, terazosin, and alfuzosin, PDE5 inhibitors such as sildenafil are effective in increasing intravaginal ejaculatory latency time (Martin 2016).

Despite recent advances, pharmaceutical treatment for premature ejaculation continues to be a difficult problem in the field of male sexual dysfunction. Although there are many studies evaluating the effectiveness of drugs used in the treatment of premature ejaculation, these studies have methodological limitations such as small sample size, absence of a placebo control group, and no randomization. Therefore, the systematic interpretation and analysis of current pharmacotherapy in the treatment of premature ejaculation are limited.

For this presentation, the main objective was to review and discuss the most prevalent treatment regimens utilized in the treatment of premature ejaculation, as well as to introduce and discuss the most recent therapy regimens under study.

References

1. Castiglione F, Albersen M, Hedlund P, Gratzke C, Salonia A, Giuliano F (2016) Current Pharmacological Management of Premature Ejaculation: A Systematic Review and Meta-analysis. European urology 69(5): 904–916.
2. Martin C, Nolen H, Podolnick J, Wang R (2017) Current and emerging therapies in premature ejaculation: Where we are coming from, where we are going. International journal of urology : official journal of the Japanese Urological Association 24(1): 40–50.

TREATMENT OF THE CIRCADIAN RHYTHM SLEEP DISORDERS

Damla Sayar Akaslan
Ankara Gülhane Eğitim ve Araştırma Hastanesi

Circadian rhythm refers to the changes in the daily physiological and biological processes of the organism. The sleep-wake cycle in humans is the most fundamental and decisive circadian rhythm. Circadian rhythm sleep disorders are common sleep disorders today. Among these disorders, there are subtypes such as delayed sleep phase disorder, early sleep phase disorder, irregular sleep-wake rhythm disorder, jet-lag type circadian rhythm sleep disorder. In the treatment of these disorders, firstly, it is aimed to eliminate the incompatibility between the disrupted sleep awake hours and the endogenous circadian rhythm, and to eliminate the symptoms of insomnia or hypersonic that occur with the disruption of the circadian rhythm, and to eliminate the deterioration in social, academic and work functionality as a result of the disorders. Treatment methods are very diverse and behavioral methods are the most important part. This treatment methods includes chronotherapy, short sleep planning and sleep hygiene. Choronotherapy is a behavioral method that provides the gradual delay sleep and shifting the sleep phase. Sleep hygiene, on the other hand, includes the arrangements made in daily habits to improve sleep quality. Other treatment methods are methods that shift the circadian phase, bright light therapy and melatonin treatment. With bright light therapy, it is aimed to rearrange the circadian rhythm by taking advantage of the phase shifting effect that changes according to the light intensity used. Melatonin is a chronobiology neuropeptide that has a phase shifting sleep-inducing effect, and its phase response curve is the reverse of bright light therapy. Stimulants and hypnotics are used against insomnia or hypersomnia symptoms resulting from circadian incompatibility. Physical activity and diet practices are also included in the treatment of circadian rhythm sleep disorders. There are differences in the ways to be followed in the treatment of each subtype. In this session, it is planed to cover each treatment method and its usage areas in detail.

STIGMATIZATION IN PSYCHOSIS AND MOOD DISORDERS

Fikret Ferzan Gıynaş

Erenköy Ruh ve Sinir Hastalıkları Eğitim ve Araştırma Hastanesi

The most important disease groups that the society does not know enough about, are afraid of, stay away from and stigmatize are mental disorders. In this patient group, where treatment and drug use are of great importance, stigmatization is at least as important as the disease (Üçok, 2003).

Although having insight into the disease increases adherence to treatment, paradoxically, especially among patients with schizophrenia, greater insight has been associated with higher levels of dysphoria, lowered self-esteem, and decreased well-being and quality of life. Existing research has confirmed a significant relationship between self-stigma and insight in patients with schizophrenia. Also, in patients with very high levels of self-stigma, higher insight is associated with more depressive symptoms (Woon et al.,2020).

Stigma occurs within affected individuals, families, social environments, work and school environments, and the healthcare industry. Stigmatization often come a loss of social support and occupational success, reduced functioning, higher symptom levels and lower quality of life (Hawke et al.,2013). In a study evaluating evidence of which interventions are effective in reducing stigma for people with severe mental illness, defined as schizophrenia, psychosis, or bipolar disorder, they found that educational interventions led to small-to-moderate reductions in stigmatization attitudes and desire for social distance (Morgan et al., 2018). It is important for chronic mental illnesses to address stigma as a part of treatment and to inform patients, families and health professionals about stigmatization.

References

1. Üçok A. (2003). Şizofreni hastası neden damgalanır?. Klinik Psikiyatri Ek. (1): 3-8.
2. Woon LS, Khoo SI, Baharudin A, Midin M. (2020). Association between insight and internalized stigma and other clinical factors among patients with depression: A cross-sectional study. Indian J Psychiatry. 62(2):186-192.
3. Hawke LD, Parikh SV, Michalak EE. (2013). Stigma and bipolar disorder: a review of the literature. Journal of affective disorders.150(2): 181-191.
4. Morgan AJ, Reavley NJ, Ross A, Too LS, Jorm AF. (2018). Interventions to reduce stigma towards people with severe mental illness: Systematiic review and meta-analysis. Journal of Psychiatric Research. (103):120-133.

STIGMA IN PERSONALITY DISORDERS

Duygu Aslan Kunt
Aydın Devlet Hastanesi

“Personality disorder” is a diagnostic construct used to label someone who experiences severe difficulties in self and interpersonal functioning and who presents with personality traits that are considered pathological in nature. Personality disorders are among the most common psychiatric conditions and 6-10% of the population is affected (Samuels 2011). Like those with other forms of mental illness, people with personality disorders experience the devastating effects of social stigma in addition to their problematic symptoms of illness.

The general public has less information about personality disorders than about other mental illnesses. Limited information about personality disorders may mean that individuals with personality disorders are excluded rather than referred for treatment, and are less likely to recognize their behavior as symptoms of the illness. Evidence suggests that personality disorders may be even more stigmatized than other psychiatric diagnoses, leading to both fear and frustration among common responses to personality disorders. The belief that people with personality disorders should be able to exert control over behavior causes symptoms to be viewed as manipulation or refusal to help. This can cause people to be viewed as difficult and mischievous rather than sick (Sheehan et al. 2016).

While lack of public awareness serves as the first barrier to seeking care, when individuals with personality disorders begin to seek treatment, they are faced with a label that may be more stigmatizing than outside of the treatment setting. Studies have found that people with a diagnosis of personality disorder are often seen by professionals as more difficult and less likely to engage in treatment. Studies have also found that negative attitudes can lead to poorer care including less empathic responses and inadequate service provision (Attwood et al. 2021)

Stigma experienced by individuals with a personality disorder threatens to compound psychiatric symptoms and compromise treatment, especially when that stigma is perpetrated by health professionals or social institutions. Designing interventions to change the stigma about personality disorders is an important effort. Limited evidence suggests that health provider training can improve stigmatizing attitudes and that interventions combining positive messages of recovery potential with biological etiology will be most impactful to reduce stigma. Anti-stigma interventions designed specifically for health providers, family members, criminal justice personnel, and law enforcement seem particularly beneficial, given these sources of stigma.

References

1. Attwood J, Wilkinson-Tough M, Lambe S, et al. (2021). Improving Attitudes Towards Personality Disorder: Is Training for Health and Social Care Professionals Effective? J Pers Disord, 35(3):409-S4.
2. Samuel J (2011). Personalitydisorders: epidemiology and public health issues. International Review of Psychiatry, 23(3), 223-233.
3. Sheehan L, Nieweglowski K, Corrigan P. (2016). The stigma of personality disorders. Current Psychiatry Reports, 18(1), 1-7.

STIGMATIZATION IN ALCOHOL AND SUBSTANCE USE DISORDERS

Mine Ergelen
Erenköy Ruh ve Sinir Hastalıkları Eğitim ve Araştırma Hastanesi

Alcohol and substance use disorder (ASUD) is recognized as one of the most stigmatizing conditions worldwide (Mak et al. 2015). Researches in this field have highlighted a deeply discrediting quality of stigma. Different types of stigma are defined as perceived stigma, experienced stigma, and self-stigmatization. Self-stigma, internalizing social stigma, and devaluating own worth cause serious psychological stress, social withdrawal, and serve as a barrier to achieve one's life goals. However, the issue of stigma has mostly been studied for other psychiatric disorders and little attention has been paid to self-stigmatization related to ASUD. In particular, the fact that people who use substances are seen as criminals in some societies may cause these people to isolate themselves from the society. Factors such as gender, education, or age and comorbidity of infectious diseases such as Hepatitis C virus (HCV) or Human Immunodeficiency virus (HIV), may also increase stigma in this group (Cheng et al. 2019). Individuals with ASUD may not only isolate themselves due to stigma, but may withdraw from substance use treatment and increase other risky behaviors (Mak et al. 2015). Studies indicate that as a result of stigma, heroin users refuse to participate in treatment services (Cheng et al. 2019). It is crucial to learn to cope with stigma in order to achieve recovery. Findings from previous studies have shown that healthcare professionals tend to use a more avoidant approach when providing healthcare to patients with alcohol and substance abuse disorders compared to those without such disorders, which may affect treatment outcomes (Yuan et al. 2018).

In the light of all this information, it is very important to address the factors affecting stigma and the consequences of stigmatization on patients' lives. Efforts to improve the attitudes of healthcare professionals towards individuals with disorders will also be one of the important steps in this regard.

References

1. Cheng CM, Chang CC, Wang JD, Chang KC, Ting SY, Lin CY (2019) Negative impacts of self-stigma on the quality of life of patients in methadone maintenance treatment: the mediated roles of psychological distress and social functioning. International journal of environmental research and public health 16(7):1299.
2. Mak WW, Ho CY, Wong VU, Law RW, Chan RC (2015) Cultural model of self-stigma among Chinese with substance use problems. Drug and Alcohol Dependence 155: 83-89.
3. Yuan Q, Seow E, Abdin E, Chua BY, Ong HL, Samari E, Subramaniam M (2018) Direct and moderating effects of personality on stigma towards mental illness. BMC psychiatry 18(1): 1-10.

NUTRITIONAL TREATMENT IN SCHIZOPHRENIA

Meltem Puşuroğlu

Recep Tayyip Erdoğan University Faculty of Medicine Department of Mental Health and Diseases

Nutritional support is increasingly important in the treatment of patients as well as drug treatment. With an accurate nutrition model, both positive progress in the course of diseases and success in preventing recurrences can be achieved by taking into account the diagnosis of the patient, possible complications and medications.(1). Schizophrenia is a chronic disease. Medical problems related to the medications used by patients, sedentary lifestyle, smoking are more common. Chronic diseases such as metabolic syndrome, diabetes and cardiovascular diseases are observed more frequently than the normal population. Metabolic side effects of antipsychotic drugs are known. A healthy diet has a positive effect on the course of the disease. In addition, studies on the lack of essential nutrients in the formation of schizophrenia, a disease that goes with neurodegeneration, are increasing. Malnutrition is a risk factor for neuropsychiatric diseases. Supplementary essential nutrients provide a protective effect (2). It is known that neuropsychiatric symptoms due to deficiencies of essential nutrients such as vitamins and amino acids have been observed since ancient times. Today, there is increasing data that schizophrenia is not only a hyperdopaminergic table, but that many pathways are effective. Hyperhomocystinemia, increased oxidative pathways, gluten sensitivity, autoimmune diseases, increased amounts of immunoglobulins due to food allergies can be considered as potential mechanisms in the pathogenesis of schizophrenia. (3). Schizophrenia is an important disease that follows with severe loss of ability. In the treatment of the disease and in the prevention of recurrences, other treatment options as well as drug treatment are becoming increasingly important. The rate of patients living a healthier life with the right diet is increasing. Therefore, lifestyle changes such as nutrition are as important as drug treatment. In addition, the importance of nutrition as a preservative in the development of schizophrenia is increasing day by day.(4).

References

1. Mete R,Emeksiz GK: Nutrisyon. namık kemal tıp dergisi 2017; 5:92-99
2. Türkoğlu İ, Yıldız E,Mercanlıgil SM: Şizofreni Hastalarında Metabolik Profil ve Diyet Örüntüsü. beslenme ve diyet dergisi 2017; 45:185-193
3. Onaolapo OJ,Onaolapo AY: Nutrition, nutritional deficiencies, and schizophrenia: An association worthy of constant reassessment. World journal of clinical cases 2021; 9:8295-8311
4. Hoffer A: Nutrition and schizophrenia. Canadian family physician Medecin de famille canadien 1975; 21:78-82

NUTRITIONAL THERAPY IN SLEEP AND WAKE DISORDERS

Arş.Gör. İbrahim Sefa Güleç

RecepTayyipErdoğan University Faculty of Medicine, Department of Psychiatry,Rize

Sleep, in humans, is defined as a complex reversible behavioural state where an individual is perceptually disengaged from and unresponsive to their environment (1). Sleep health is important for the individual to live in physical and mental well-being. Good sleep health is characterized by appropriate timing, sufficient duration, and high efficiency. The circadian rhythm is of great importance in good sleep health. The circadian rhythm is controlled by the suprachiasmatic nucleus (SCN). Many factors are effective in the circadian regulation of sleep and sleep. One of these factors is diet. Diet is believed to play an important role in the regulation of sleep wellness (2). The mechanism for diet in the regulation of sleep is a very complex question that could be demonstrated through the following pathways. First, diet components can directly affect sleep. For example, caffeine which is contained in caffeinated coffee or tea causes a decrease in total sleep time and quality, as well as an increase in sleep induction time. Caffeine is chemically related to adenosine, which is a sleep-inducing agent. It is believed that caffeine works by reversibly antagonizing the sleep-inducing adenosine receptors (A2AR) in the brain, although other pathways may co –exist (2). Secondly, many nutritional metabolites can be bioactive in sleep regulation directly or through the regulation of other relating factors as discussed below. It should be noted that nutrition could significantly alter the commensal microbiota which could affect the metabolic generation of metabolites (2). Thirdly, long-term nutritional factors could alter the inflammation status which is also closely related with insomnia. This has been supported by substantial number of studies that sleep disturbance is related with altered circulating inflammatory cytokines (especially C-reactive protein and interleukine 6) and glucocorticoids (2). In the third case, although studies have been conducted on the relationship between inflammation, sleep and nutrition, the results of these studies are inconsistent. Recently, studies on the role of diet in sleep- and sleep disorders have increased dramatically. Although studies have conflicting results, they reveal the relationship between nutrition and sleep. These contradictory results are thought to be due to the complex structure of nutrients. Therefore, studies using refined nutritional ingredients have reached more accurate results. In this presentation, the relationship between sleep and sleep disorders and nutrition will be discussed in the light of current literature findings.

References

1. Doherty, R., Madigan, S., Warrington, G., & Ellis, J. (2019). Sleep and nutrition interactions: implications for athletes. *Nutrients*, *11*(4), 822.
2. Zhao, M., Tuo, H., Wang, S., & Zhao, L. (2020). The effects of dietary nutrition on sleep and sleep disorders. *Mediators of inflammation*, *2020*.

REPRESENTATION AND DIFFERENCE OF PSYCHOSIS

Yusuf Dökmen

MD, Sakarya Training and Research Hospital Department of Psychiatry

Abstract

As the Psychiatry and Philosophy Working Unit, we tried to analyze Deleuzu's doctoral thesis, Difference and Repetition. Considering the other works of the philosopher, what kind of meaning they attributed to schizophrenia was examined and an approach to psychosis was tried to be developed by taking inspiration from this.

Since psychiatry is still very young and still striving to become a positive science, it is very open to the interventions of philosophy, which can be manipulative from time to time. As psychosis, which is the main field of activity of psychiatry, and as its sub-type, schizophrenia has been tried to be contracted and expanded through various channels of philosophy. Gilles Deleuze, one of the most original and creative philosophers of the twentieth century, and Guattari, the leading theorist of the La Borde clinic, chose psychosis as one of their production and challenge fronts. In Anti-odipus, which can be seen in a reformist antipsychiatry literature, deleuze and gattari open up schizophrenia to very broad perspectives, and they have gained a more positive manner by removing it from the pattern of deficiency, weakness, which is clinically defined as negativity and a rupture from reality (schizo-phrenia). In their own words, "The schizophrenic person is in a position close to the beating heart of reality, an intense point identical to the production of reality." We can call this the positive theory of schizophrenia. In Deleuze's philosophy, schizophrenia can have a clinical meaning beyond a metaphor describing the disruption of boundaries. This is the meaning of the experience of "intensity order", with an expression taken from "Difference and Repetition", without any emptiness and form confusion.Another Deleuzian meaning is the schizophrenia as a state of rebellion against the representation system that eliminates difference. There is no doubt that psychosis, with this newly acquired conceptuality, can be conceived without prejudice as a revolutionary structure, far from romanticizing it.

References

1. Gilles DELEUZE , Difference and Repetition
2. Gilles DELEUZE and Felix GUATTARİ, Anti-Oedipus
3. Aaron SCHUSTER, The Trouble with Pleasure

DOES PSYCHOANALYSİS HAVE ANY DİFFERENCE?

Cengiz Arca

In these days when Sigmund Freud celebrated his 166th birthday, the debate about psychoanalysis still continues. Psychoanalysis is an object of interest not only in the field of mental health but also in many fields. Using their own mix of poststructural theory and original philosophical concepts, Deleuze and Guattari articulated an explanation of how the structure of psychoanalytic thought relates to the material conditions of imperialism and capitalism, in 1972, exactly 50 years ago. For Deleuze ve Guattari psychoanalysis, had a revolutionary aspect at the earlier periods of its development. However, it took a turn and became something repressive. This tendency of decay in psychoanalysis is resembled to the Russian Revolution: "psychoanalysis is like the Russian Revolution, we don't know when it started going bad." They argue that psychoanalysis reduces the desiring production to representation, and the Oedipus complex becomes an apparatus for repressing all kinds of desiring machines. So when did the psychoanalysis go wrong? "Deleuze and Guattari do not reject psychoanalysis," Ian Buchanan affirms. "Contrary to popular myth, they explicitly state that 'they refuse to play the take it or leave it games". Discussions about psychoanalysis have focused on two issues: originality and scientificity. It is possible to say that psychoanalysis is not directly based on scientific data and that empirical observations are advancing. But how scientific does psychoanalysis have to be? Another point of discussion is originality, that is, was what psychoanalytic theory said something that has not been said before. Deleuze and Guattari celebrate what they call "the primary inspiration of psychoanalysis": the discovery of the unconscious, of the essence of desire. It does not correspond, at the beginning, to the establishment of a new dogma, but to the appearance of a force capable of turning all dogmas upside down. Nevertheless, this initial explosion of life seemed to have been immediately suffocated. How? First, by the inevitable feeling of guilt Oedipus produces: either one is guilty of avenging the father and possessing the mother or of not doing either. Second, for the bad conscience that produces the interiorization of resentment for not doing what one wants, resentment for not being able to do it without guilt, but basically, due to an ascetic ideal that both guilt and bad conscience presuppose. Guilt, bad conscience, and the ascetic ideal are three diseases that Nietzsche diagnoses in On the Genealogy of Morals and that Deleuze and Guattari attribute to psychoanalysis.

References

1. Deleuze, Gilles and Félix Guattari. 2000 [1972]. Anti-Oedipus.
2. Deleuze, Gilles. 1994 [1968]. Difference and Repetition
3. Cherniavsky, Axel. 2021. Is Anti-Oedipus Really a Critique of Psychoanalysis? Comparative and Continental Philosophy

THE DIFFERENCE OF PSYCHODRAMA: PLAY, ROLES AND REPRESENTATIONS

Dr. Merve Cura

Ankara Dr. Sami Ulus Kadın Doğum Çocuk Sağlığı ve Hastalıkları Eğitim Araştırma Hastanesi, Çocuk ve Ergen Ruh Sağlığı ve Hastalıkları Anabilim Dalı

Psychodrama is a theory that deals with mental processes with an inter-psychic focus. Moreno's basic concept is that internal conflicts arise within social structures such as family and society, as a result of interaction with the outside world. The form of function used by the person at that particular moment in which he or she reacts to a particular situation involving other people or objects is called a "role". Roles are part of the interpersonal system. According to Moreno, the visible aspects of what is called the self are the roles used by the individual and the pattern of relations between these roles. The breadth and flexibility of the role repertoire is the richness and power of the self. Restrictions here prevent spontaneity and creativity. Roles that cannot be expressed put pressure on the apparent role and cause anxiety. According to psychodrama theory, this is the source of conflict and anxiety. In order to resolve this, Moreno exhibits and works with the object relations of the person by staging conflict situations in a group.

Conflict is enacted in a group setting and under the direction of an experienced therapist, using the stage and other group members. During this staging, the entire psychic system of the protagonist is brought to the stage with techniques such as the use of "auxiliary selves", matching, role switching, and mirror technique. In the resulting game, the entire inner object world of the protagonist is embodied and provides the protagonist with the opportunity to consciously navigate this world and make new arrangements with the help of the manager. The manager tries to make the protagonist understand what he is doing and why, and to see unconscious patterns of emotion, thought and behavior that hinder his creativity and spontaneity.

The goal of psychodrama is parallel to that in the psychoanalytic therapy process: to create the conditions that allow for the development of a real transference and a bearable level of investment. In other words, it is to repeat the investments made in parental representations in the relationship, to recognize the inner spiritual reality, to reconstruct the childhood story by establishing a link between the present and the past story of the subject.

What is the difference of psychodrama? With a large number of actors, psychodrama removes the traumatic stalemate created by a dual relationship involving threats to the object. The therapy manager is inevitably in the superego position and assumes the functions of attachment and warning shield. Under his protective gaze, co-therapists have the freedom to play with the patient's lives much more closely. They can play any necessary variety of representations of the patient's inner world: ego-lower-ego-superego representations, primal transferences, oedipal parent figures or siblings. The aim here is to gamify rather than act. Through pretending, the act of play becomes only an illustration of phantasy. It is the game itself, which, through the movement it produces, reworks a malfunctioning psychic dynamic.

References

1. Moreno J. L. (1977) Psychodrama. Beacon House, New York.
2. Özbek A. and Leutz G. (1987) Psikodrama: Grup Psikoterapisinde Sahnesel Etkileşim, Abdülkadir Özbek Psikodrama Enstitüsü, Ankara, Turkey
3. Moreno J.L. (1953) Who Shall Survive? Foundations of Sociometry, Group Psychotherapy and Sociodrama, Beacon House, New York.

EARLY COGNITIVE PROBLEMS AND CHRONICITY IN PATIENTS WITH MOOD DISORDERS

Assoc. Dr. Cânâ Aksoy Poyraz
Istanbul University-Cerrahpaşa Medical Faculty

Pseudodementia is a clinical syndrome that resembles or mimics dementia, but the main feature that distinguishes this condition from dementia is that it can be improved when an appropriate treatment is applied. Dr. Wells defined pseudodementia as a mental illness, imitating dementia or caricaturazing dementia; this condition appeared in the course of various clinical pathologies, such as personality disorder, schizophrenia, and mood disorders in his patients. However, in many other studies, pseudodementia has been shown to be most associated with depression. The main factors that attract attention in distinguishing cases of pseudodementia from dementia can be summarized as having a mental disorder in the past, bringing the patient to the clinic shortly after the appearance of symptoms, rapid progression of symptoms and the mismatch between the performance in cognitive functions and the apparent cognitive impairment in the assessment questions, as well as the predominance of "I don't know" answers.

In the 1980s and 1990s, research and case reports on the subject increased, but since the 2000s, interest in the subject has been declining in neuropsychiatric publications. Some researchers believe that one of the reasons for this is that the term pseudodementia misleads experts. In these studies, it is claimed that the presentation of the existing disease is in fact a kind of dementia. Because today, it is not sought to have an irreversible or progressive course of the disease in order to diagnose dementia, as in the 1960s. However, the validity of this clinical diagnosis has been questioned in long-term follow-up studies, and many studies have shown that cognitive impairments persist even after depression. Therefore, the extent to which this clinical picture is reversible is debated. Some researchers note that a significant proportion of patients diagnosed with pseudodementia are diagnosed with dementia after many years. However, this pattern is not suitable for every patient. Because there are researchers who show the exact opposite, that is, the rate of conversion to dementia is extremely low. Although the term pseudodementia describes a group of patients, it seems difficult to name it as a diagnosis. Current studies show that the frequency of this clinical condition is not low. In conclusion, there is a need for new research based on research techniques that use biological indicators or neuroimaging in order to better understand this clinical entity, which can be cured with an early diagnosis and proper treatment.

COGNITIVE COMPLAINTS AT EARLY AGE AND POTENTIAL CAUSES

N. Gamze Usta Sağlam, MD

Istanbul Erenkoy Mental and Nervous Diseases Training and Research Hospital, Department of Psychiatry

In patients presenting with cognitive complaints, evaluation of the onset history, course, and character of the symptoms is essential. Especially in atypical and early-onset cases, obtaining a detailed family history of psychiatric and neurological diseases is crucial. In the patient's history, trauma, alcohol-substance use disorders, seizures and fainting, situations that may pose a risk of toxicity, etc. should be questioned in detail. Depression and anxiety symptoms should be carefully examined in the mental state examination. Changes in personality, behavioral disturbances and psychotic features are other significant psychiatric symptoms that could guide the differential diagnosis. Although standard psychometric tests are generally useful, it should be kept in mind that they are not diagnostic. Evaluation of functionality is critical in the complete evaluation of the patient. Findings such as headache, visual impairment, vomiting, and seizures are among the alarming signs. Physical and neurologic examination and, in certain circumstances such as the probability of increased intracranial pressure, Wilson disease, etc. optic examination can be performed. Subjective cognitive complaints at an early age can be quite common, which could be defined as despite the reports of a patient worsening of oneself's cognitive abilities, the decline cannot be verified by standard tests. This situation is usually associated with some emotional, psychological, and behavioral factors. The most common etiologies that can cause cognitive problems at an early age are; multiple sclerosis, neurosarcoidosis and paraneoplastic/ autoimmune limbic encephalitis from inflammatory processes; HIV dementia and neurosyphilis from infectious etiologies, effects of alcohol and substance use and heavy metal poisoning from toxic etiologies; endocrinopathies, normal pressure hydrocephalus, Wilson's disease and traumatic brain injury will be briefly mentioned with their presentation to psychiatry clinics.

In this panel discussion, the evaluation process and possible differential diagnoses in early-aged patients with cognitive problems at the forefront will be discussed in the light of current literature.

??????????

Gözde Dünya Er

George Engel stated that the clinical interview in medicine is “almost indispensable for physician-patient interaction” and that “well-structured interview can be seen as the most powerful, sensitive and versatile tool for the physician”. Despite advances in science and technology, this statement still remains true today, and in no field of medicine is it more evident than in the practice of psychiatry.

The mental state examination is the functional equivalent of the physical examination in other medical fields. Theoretical efficiency is over emphasized during psychiatry training while trainees are usually expected to develop psychiatric interviewing skills on their own. Although theoretical education is indispensable in the process of psychiatry training, it is not sufficient on its own. It is not possible to develop psychiatric interviewing skills without practice.

Psychiatric interview is like a fine art that should be built up with proper training and practice. Psychiatric interviewing requires empathy, which is understanding why and how the patient thinks and feels that way, and knowing the patient’s experiences and perspective in detail and in depth.

Before conducting a patient interview that requires experience, one of the best ways to prepare for this interview is re-enactment. Even though it is not being utilized as much as necessary during psychiatry training, role-playing the patient-physician interview is one of the most basic ways to develop psychiatric interviewing skills.

In our event, “Re-enacting the Patient-Physician Interview in Psychiatry (Role Play)”, we will portray the interviews of 3 different sample patient cases. In the first case, we will portray a young adult patient with suicidal thoughts. In the second case, we will depict a male patient who denies having a problem with alcohol use and brought by his family forcibly. In the last case, we will portray an older lady who has somatic complaints due to social stressors, who states that they have not benefited from any prior treatment.

We will ask the volunteers from our audience to play the doctor. Before the role play is commenced, speaker will give a brief information about the patient they will portray. After a role play of 5 to 10 minutes has concluded we will evaluate the interview and re-enactments with our supervisors.

Through this event, we aim to encourage trainees to perform role play in order to flourish psychiatric interviewing skills.

THE ROLE OF THE TRADITIONAL AND NEW MEDIA IN STIGMA OF SEXUALITY

Arzu Erkan, M.D., Asst. Prof.

Department of Psychology, Istanbul Kultur University, Istanbul, Turkey

According to the World Health Organization, sexual health is: “a state of physical, emotional, mental and social well-being concerning sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships and the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled.”(1) “Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.” (2).

Human sexuality should be experienced away from violence, stigma, and discrimination worldwide to reach accurate information and resources to benefit.

Information regarding relational and sexual life takes place in traditional and new media, whether explicitly or implicitly, and shapes the cultures globally. While productions that adopt social gender equality and rights-based perspective greatly benefit in combating sexual stigma, discrimination, and inequality, the sloppy contents increase stigma, leading to the reproduction of inequality and violence.

Stigmatizations are widely seen in advertisements, TV programs, movies, novels, magazines, newspapers, lyrics, screenplays, academic works, news, and social media posts. Stigmatization can be related to expressing sexual identity, orientation, and feelings, when and with whom the first sexuality/sexuality will/will not be experienced, masturbation, virginity, pregnancy, birth control, abortion decision, infertility, sexually transmitted diseases, body appearance, sexual performance, approval, reciprocity, and satisfaction in relationships, confidentiality and privacy, marital rape and exposure to sexual violence, and etc. (3).

The privacy, shame, and marginalization caused by stigmatizations negatively affect people’s mental health by preventing them from accessing the correct information and resources and making informed decisions. People have difficulties in accessing sexual/reproductive health services. Using media-new media correctly, changing stigmatizing and discriminatory social norms, transferring healthy information on sexual health and rights, increasing social awareness, and spreading the culture of approval; can be powerful tools for normalizing safe sexual behavior without coercion and sexual violence.

In this panel, the positive and negative roles and responsibilities of the media-new media and mental health experts in determining and stigmatizing the attitudes and behaviors of society towards sexuality will be discussed, and updated information will be conveyed.

References

1. WHO. Sexual Health; 2018. http://www.who.int/topics/sexual_ health/en/
2. UNESCO. International Technical Guidance on Sexuality Education: An Evidence-Informed Approach for Schools, Teachers and Health Educators. Volume I and II; 2018. http://unesdoc. unesco.org/images/0026/002607/260770e.pdf
3. https://www.cetad.org.tr/CetadData/Books/52/bilgilendirme-dosyasi-10-escinselllik.pdf

THE ROLE OF SOCIAL MEDIA IN THE FORMATION OF SEXUAL ATTITUDES

Süreyya Akyıldırım Çor, M.D.,

Gulhane Training & Research Hospital for Psychiatry Ankara Turkey

Sexual behavior patterns have a quality that reflects the biopsychosocial health status for clinicians working in the field of mental health. and provides clinical benefit in this respect. Sexual behaviors have a much broader meaning that encompasses not only physical practices, but also attitudes, experiences, desires, preferences, and a variety of related psychological and social phenomena.

Attitude is a general evaluation based on cognitive, emotional and behavioral information about an attitude object. The fact that an attitude is an evaluation always and necessarily means that it includes a judgment. In other words, having an attitude is by definition being biased.

According to American Psychological Association, sexual attitude means "values and beliefs about sexuality. Manifested in a person's individual sexual behavior, these attitudes are based on family and cultural views about sexuality, on sex education, and on prior sexual experiences". Accordingly, sexual attitudes are based on information that is true or false.

The reasons why sexual attitudes are an important research topic are, the assumption that attitudes determine behaviors, the decisive effect of attitudes on processing information about the attitude object, and the decisive effect of attitudes in regulating interpersonal relationships.

When we analyze the determinants of sexual attitude, family structure comes first. Individuals apply what they see from their families in their own lives and take their families as role models.

Other factors are the personality organization of the individual, the environment he/she lives in, the education he/she receives, the religious belief, the cultural structure of the society in which he/she grows up, the friends of the individual, and the sexual experiences.

Social media differ in many aspects from traditional or industrial media in terms of quality, reach, frequency, usability, proximity, persistence, visibility, reviewability, editing ability, and attribution. Social Media, which is user-oriented and where everyone has the right to speak without any limitations, has a great impact on the society as it is a living platform, unlike newspapers, television and other printed media, as it has simultaneous information sharing and two-way communication and can reach very large masses instantly.

In the report published with the partnership of "Hootsuite" and "We Are Social", in which statistical data in the digital world are presented on a global and country basis; as of April 2022, it has been reported that 67% (5.32 billion people) of the world's population of 7.93 billion people use mobile phones and 63%(5 billion people) are internet users.

Sexual content is a fundamental element of social media. The sexual content referred to herein is verbal or visual references to sexual relationships, dating or sexual acts (Ie, not obscene media/pornography). Analyzer's have estimated that 81% of major motion pictures and 82% of television shows contain sexual content. While sexual content is widespread, it is not uniform and includes some themes more than others.

In this panel; It will be discussed how the concept of sexual attitude, which requires a multidimensional evaluation, is shaped by social media.

References

1. Franzoi, L. S. (2003). Social Psychology (Third Edition). Boston: McGraw-Hill.
2. Karaçam, Özgür, et al. "Hendrick Cinsel Tutum Ölçegi Kisa Formunun Türkçeye uyarlanmasi, geçerlilik ve güvenilirlik çalismasi/Turkish adaptation of the Hendrick Brief Sexual Attitudes Scale, validity and reliability study." Anadolu Psikiyatri Dergisi 13.2 (2012): 138.
3. https://hootsuite.widen.net/s/zcdrtxwczn/digital2021_glob alreport_en
4. Braun-Courville, Debra K., and Mary Rojas. "Exposure to sexually explicit web sites and adolescent sexual attitudes and behaviors." Journal of adolescent health 45.2 (2009): 156-162.
5. McCoy, Elizabeth K. The Impact of Social Media Use on the Acceptance of Rape Myths and Subsequent Views on Sexuality. Diss. Ohio Dominican University, 2020.
6. Coyne, Sarah M., et al. "Contributions of mainstream sexual media exposure to sexual attitudes, perceived peer norms, and sexual behavior: A meta-analysis." Journal of Adolescent Health 64.4 (2019): 430-436.
7. Escobar-Chaves, S. Liliana, et al. "Impact of the media on adolescent sexual attitudes and behaviors." Pediatrics-English Edition 116.1 (2005): 303-326.
8. Soydaş, Ebru. Cinsel tutumların evlilik uyumuna ve cinsel işlev bozukluklarına etkisi. MS thesis. Sosyal Bilimler Enstitüsü, 2016.

THE ROLE OF THE MEDIA IN SEXUAL VIOLENCE BEHAVIOR

Burak Amil, MD.
Department of Psychiatry, Medipol University, Istanbul, Turkey

In recent years, there has been an increase in the visibility of examples of sexual violence behavior in the media. As a result of this situation, the effective use of media tools in the prevention of sexual violence has become a point of contention. The manner in which sexual violence is reported in the media is a critical issue. These stories should be free of sexism and should not cause social trauma. The way some violent events with magazine elements are presented in the media, in particular, raises concerns about media ethics. What is society's reaction to media depictions of sexual violence? How do people's perceptions of sexual violence behavior change as a result of hearing about it in the news? Various studies are being conducted to attempt to answer all of these questions. All of these issues will be discussed in depth in this presentation, with current examples from the literature and references from study findings.

References

1. Frentzen, E., Reisacher, D., Brähler, E., Rassenhofer, M., Fegert, J. M., & Witt, A. (2022). The Predictors of Awareness of Sexual Abuse and Sexual Violence in the Media and the Influence on Actions of the Individuals. Frontiers in psychiatry, 12, 789144. https://doi.org/10.3389/fpsyt.2021.789144
2. Rodenhizer, K. A. E., & Edwards, K. M. (2019). The Impacts of Sexual Media Exposure on Adolescent and Emerging Adults' Dating and Sexual Violence Attitudes and Behaviors: A Critical Review of the Literature. Trauma, Violence, & Abuse, 20(4), 439–452. https://doi.org/10.1177/1524838017717745
3. Egen O, Mercer Kollar LM, Dills J, et al. Sexual Violence in the Media: An Exploration of Traditional Print Media Reporting in the United States, 2014–2017. MMWR Morb Mortal Wkly Rep 2020;69:1757–1761. DOI: http://dx.doi.org/10.15585/mmwr.mm6947a1external icon.