PSYCHIATRIC ASSOCIATION OF TÜRKİYE ANNUAL MEETING &

4th INTERNATIONAL AND 28th NATIONAL CLINICAL EDUCATION SYMPOSIUM

Speaker Abstract Book

19 - 22 April **2026**

Pine Beach Hotel and Convention Center

Antalya

PSYCHIATRIC ASSOCIATION OF TÜRKİYE

www.psikiyatri.org.tr

www.28.psikiyatri.org.tr

ORGANIZING SECRETARIAT

www.zevent.com.tr

EXECUTIVE COMMITTEE

PSYCHIATRIC ASSOCIATION OF TÜRKİYE - CENTRAL EXECUTIVE BOARD PRESIDENT

Serap Erdoğan Taycan

Istanbul Okan University (Istanbul) VICE PRESIDENT

Ejder Akgün Yıldırım

University of Health Sciences, Bakırköy Prof. Dr. Mazhar Osman Psychiatric and Neurological Diseases Health Application and Research Center (Istanbul)

GENERAL SECRETARY

Zuhal Kamış

Ankara Bilkent City Hospital (Ankara) TREASURER

Gülin Özdamar Ünal

Süleyman Demirel University (Isparta) ORGANIZING SECRETARY

Şahut Duran

Private Practitioner (Izmir)

RESIDENT REPRENSENTATIVE / SECRETARY

Alperen Yıldız

University of Health Sciences, Bakırköy Prof. Dr. Mazhar Osman Psychiatric and Neurological Diseases Health Application and Research Center (Istanbul)

EDUCATION SECRETARY

Uğur Çıkrıkçılı

Otto von Guericke University, Institute of Behavioral Neurology and Dementia Research (Germany)

CONGRESS ORGANIZING COMMITTEE

CHAIR OF THE COMMITTEE

Nalan Kalkan Oğuzhanoğlu Pamukkale University (Retired Faculty Member)

CHAIR OF THE SCIENTIFIC PROGRAM COMMITTEE

Şebnem Pırıldar

Ege University Faculty of Medicine (Izmir) SCIENTIFIC PROGRAM COMMITTEE

- Yasin Hasan Balcıoğlu

Bakırköy Prof. Dr. Mazhar Osman Psychiatric and Neurological Diseases Training and Research Hospital (Istanbul)

- Eren Yıldızhan

Bakırköy Prof. Dr. Mazhar Osman Psychiatric and Neurological Diseases Training and Research Hospital (Istanbul)

ORGANIZING COMMITTEE

- Emre Cem Esen

Izmir Economy University and Izmir Eşrefpaşa Hospital (Izmir)

- Sinay Önen

University of Health Sciences, Bursa Yüksek İhtisas Training and Research Hospital (Bursa)

- Hayriye Mihrimah Öztürk

Kırıkkale University Faculty of Medicine (Kırıkkale)

- Merve Gümüşay

Haydarpaşa Numune Training and Research Hospital (Istanbul)

- İmge İlke Küçük

University of Health Sciences, Bakırköy Prof. Dr. Mazhar Osman Psychiatric and Neurological Diseases Health Application and Research Center (Istanbul)

SCIENTIFIC PROGRAM ADVISORY BOARD

- Ömer Aydemir - Manisa Celal Bayar University, Türkiye
- Memduha Aydın - Selçuk University, Türkiye
- Mehmet Hamid Boztaş - Bolu Abant İzzet Baysal University, Türkiye
- Selçuk Candansayar - Gazi University, Türkiye
- Giuseppe Fanelli - University of Udine, Italy
- Joan Marsh - The Lancet Psychiatry, United Kingdom
- Emre Mutlu - Hacettepe University, Türkiye
- Edoardo G. Ostinelli - University of Oxford, United Kingdom
- Osman Özdel - Pamukkale University, Türkiye
- Thomas Pollmacher - Clinical Center Ingolstadt, Germany
- Howard Ryland - University of Oxford, United Kingdom
- Tuğçe Toker Uğurlu - Pamukkale University, Türkiye
- Simavi Vahip - Ege University, Türkiye
- Işıl Vahip - Ege University, Türkiye
- Christiaan Vinkers - Amsterdam UMC, Netherlands
- Hale Yapıcı Eser - Koç University, Türkiye

Self-Regulation Disorder Is The Prominent Pathology Underlying ADHD

Emre Cem Esen
İzmir Metropolitan Municipality Eşrefpaşa Hospital and İzmir University of Economics Faculty of Medicine

Attention-deficit hyperactivity disorder (ADHD) has been historically regarded as a disorder of attention. However, contemporary evidence, including the data on cognitive neuroscience, suggests that self-regulation disorder may be the prominent pathology underlying ADHD, rather than attention deficit, which is suggested to be regarded as a symptom instead of the core problem.

Self-regulation means guiding behavior over time to meet internal goals, integrating thinking (cognition), feeling (emotional processes), and motivation (goal-directed drive). From a neurocognitive perspective, self-regulation relies on distributed frontostriatal and frontoparietal networks. These networks involve the dorsolateral prefrontal cortex and the anterior cingulate cortex. Both areas connect with basal ganglia structures. Behavioral inhibition is foundational in this framework. It supports executive functions. These include working memory, temporal foresight, and emotional regulation.

Research shows that executive functions, especially inhibitory control and working memory, predict ADHD severity better than attentional tests alone. Neuroimaging studies support this viewpoint. They show dysregulation in large brain networks for goal control and internal monitoring. Inefficient suppression of the default mode network during tasks leads to greater performance variability. This variability is a core feature of ADHD. Fluctuations in regulatory control, not stable attention deficits, better explain it.

Self-regulation in ADHD goes beyond "cold" cognitive processes and includes affective domains. Emotional dysregulation is central. It links to altered limbic-prefrontal circuits, including the amygdala and ventromedial prefrontal cortex. These findings show that ADHD involves both impaired cognitive control and emotional regulation disruptions. This supports the idea of broad regulatory dysfunction.

Motivational neuroscience adds another explanatory layer. Altered dopaminergic signaling in mesolimbic pathways, especially in the ventral striatum, is connected to reduced sensitivity to delayed rewards. People with ADHD instead prefer immediate reinforcement. In dual-pathway and self-determination theories, this reflects disrupted prospective, goal-based self-regulation. It does not indicate a core attention deficit.

Overall, these findings suggest that ADHD’s attentional problems may result from disturbed self-regulatory control. In clinical settings, the main challenge is not just attention in the moment. The issue is in sustaining, coordinating, and regulating behavior over time. Reframing ADHD as a

self-regulation disorder brings together evidence from cognitive, emotional, and motivational studies. This view fits its neurobiological basis. It also provides a coherent research and intervention framework.

References

1. Barkley, R. A. (2012). Executive functions: What they are, how they work, and why they evolved. New York: Guilford Press.
2. Castellanos, F. X., & Proal, E. (2012). Large-scale brain systems in ADHD: beyond the prefrontal-striatal model. Trends in cognitive sciences, 16(1), 17–26.
3. Shaw, P., Stringaris, A., Nigg, J., & Leibenluft, E. (2014). Emotion dysregulation in attention deficit hyperactivity disorder. The American journal of psychiatry, 171(3), 276–293.

Symptom-Focused Cognitive Behavioral Therapy: Short-Term, Structured Interventions

Emre Cem Esen
İzmir University of Economics, Faculty of Medicine, Department of Psychiatry, İzmir, Türkiye;
İzmir Metropolitan Municipality Eşrefpaşa Hospital, Department of Psychiatry, İzmir, Türkiye

Anxiety disorders are frequently encountered in psychiatric outpatient care, where limited consultation time, high patient volume, and uncertain continuity can restrict access to full-length psychotherapy. Brief, symptom-focused cognitive behavioral therapy (CBT) offers a structured way to translate evidence-based principles into these settings without reducing treatment to non-specific support (Cully and Teten 2008, Bennett-Levy et al. 2010). Its purpose is not to replace comprehensive psychotherapy, but to identify a clinically meaningful target, develop a concise formulation, and select interventions that can produce change within the available therapeutic frame.

This presentation introduces a practical formulation organized around four interrelated mechanisms: exaggerated expectations of danger, distorted appraisals and beliefs, avoidance, and safety-seeking behaviors. Distorted appraisals may concern the probability or severity of the feared event, the meaning of physiological or cognitive anxiety symptoms, or the person's ability to tolerate and cope with distress. Avoidance and safety-seeking may provide immediate relief, but they also prevent objective re-evaluation of feared outcomes and maintain symptoms through negative reinforcement. Using examples from panic disorder, agoraphobia, social anxiety disorder, and specific phobias, the presentation will demonstrate how triggers, predictions, anxiety responses, coping behaviors, and their short- and long-term consequences can be mapped rapidly in routine practice.

The intervention sequence begins with psychoeducation about the physiology of anxiety and the cognitive behavioral model. Cognitive restructuring is then used to clarify and examine catastrophic interpretations. Graded exposure, combined with the intentional reduction of avoidance and safety-seeking, creates opportunities to evaluate feared consequences and develop more functional coping strategies. Behavioral experiments are emphasized as a particularly useful method: the patient and clinician specify a prediction in advance, observe what occurs, compare the anticipated and actual outcomes, and revise beliefs based on repeated experience (Farmer and Chapman 2025).

The presentation will also address the boundaries of this approach. Symptom-focused CBT primarily targets mechanisms maintaining the current disorder and may insufficiently address developmental factors, intermediate and core beliefs or schemas, interpersonal patterns, emotion-regulation difficulties, or the possible coping function of symptoms. More comprehensive or longer-term psychotherapy should therefore be considered when difficulties

are pervasive, recurrent, highly complex, or not adequately explained by the initial formulation. Participants will gain a concise framework for deciding for whom, at what stage, and with which targets brief symptom-focused CBT can be used, while recognizing when a broader therapeutic approach is indicated.

References

1. Bennett-Levy J, Richards D, Farrand P et al. (2010) Oxford Guide to Low Intensity CBT Interventions. Oxford, Oxford University Press.
2. Cully JA, Teten AL (2008) A Therapist's Guide to Brief Cognitive Behavioral Therapy. Houston, Department of Veterans Affairs South Central Mental Illness Research, Education, and Clinical Center.
3. Farmer RF, Chapman AL (2025) Reducing distress and avoidance through exposure-based interventions. Behavioral Interventions in Cognitive Behavior Therapy: Practical Guidance for Putting Theory into Action, 3rd ed., RF Farmer, AL Chapman (Ed), Washington, DC, American Psychological Association, p. 257-284.

Reward Valuation and Reward Processing in Behavioral Addictions

Oğuz Peker
Assistant Professor, Department of Psychiatry, Ankara Yıldırım Beyazıt University Faculty of Medicine; Ankara Bilkent City Hospital, Ankara, Türkiye

Behavioral addictions constitute a heterogeneous group of disorders with diverse clinical presentations; however, they can be understood through shared impairments in reward processing, learning, and decision-making mechanisms. Neurobiological evidence in this field has become particularly prominent through studies on gambling disorder. In this talk, behavioral addictions will be discussed within the framework of reward valuation and reward processing. Reward valuation refers to the degree of importance, attractiveness, and motivational salience attributed to a particular behavior or stimulus, whereas reward processing denotes how reward is represented across the phases of anticipation, outcome, and feedback.

The reinforcement learning framework provides a functional model for understanding behavioral addictions. According to this perspective, an organism selects a behavior in a given context, encounters an outcome, and subsequently updates future behavior on the basis of that outcome. In addiction, one of the core impairments is the failure of this updating process to operate efficiently despite negative consequences. As a result, the behavior persists without adequately incorporating its true costs. From the perspective of reward valuation, regions such as the ventromedial prefrontal cortex (vmPFC) and ventral striatum are thought to encode different types of rewards within a common value space; in behavioral addictions, certain behaviors may become pathologically overvalued (Hélie et al., 2022).

Reward processing is not a unitary phenomenon. Reward anticipation, reward outcome, and prediction error represent dissociable yet interrelated phases. Neuroimaging meta-analyses suggest that distinct neural patterns may emerge during the anticipation and outcome phases of reward processing in addiction. These findings indicate that impairments in behavioral addictions cannot be sufficiently explained by a unidimensional increase in reward sensitivity alone (Luijten et al., 2017). Gambling disorder represents one of the most robust models for understanding these mechanisms, as reward anticipation, risk, loss, uncertainty, and feedback can all be observed within a single behavioral paradigm. Furthermore, findings from delayed reward discounting demonstrate the temporal dimension of disrupted reward valuation, whereby individuals preferentially choose smaller immediate rewards over larger delayed ones.

In conclusion, behavioral addictions cannot be reduced to a simplistic impulsivity framework; rather, they are characterized by impairments in reward valuation, reward processing, and decision-making processes. This perspective offers a more integrative framework for both clinical assessment and theoretical conceptualization.

References

1. Hélie S, Shamloo F, Novak K, Foti D (2022) The roles of valuation and reward processing in cognitive function and psychiatric disorders. Ann N Y Acad Sci 1511: 33-48.
2. Luijten M, Schellekens AF, Kühn S et al. (2017) Disruption of reward processing in addiction: An image-based meta-analysis of functional magnetic resonance imaging studies. JAMA Psychiatry 74: 387-98.
3. Potenza MN (2013) Neurobiology of gambling behaviors. Curr Opin Neurobiol 23: 660-7.

Pre-transplant Psychosocial Assessment and Post-transplant Psychiatric Follow-up in Organ Transplant Recipients

Oğuz Peker
Assistant Professor, Department of Psychiatry, Ankara Yıldırım Beyazıt University Faculty of Medicine; Ankara Bilkent City Hospital, Ankara, Türkiye

Psychiatric assessment in organ transplant recipients is not merely a one-time procedure performed for transplant board approval; rather, it is a dynamic and multistage process that directly influences transplant outcomes. In the pre-transplant period, the primary objective is the comprehensive evaluation of current psychiatric disorders, substance use history, decision-making capacity, coping skills, social support systems, and prior treatment adherence. This multidimensional approach is critical for predicting adherence to the complex immunosuppressive treatment regimen required after transplantation (Sarkar et al., 2022; DiMartini et al., 2011). In particular, active substance use, marked lack of social support, a history of severe treatment nonadherence, high suicide risk, and significant cognitive impairment represent major red flags that may jeopardize transplant success.

The waiting-list period is among the most psychologically vulnerable phases of the transplant trajectory. During this stage, patients are not only awaiting an organ but are also living with the possibility of death, uncertainty, and intense time pressure. Anxiety, depressive symptoms, insomnia, and social withdrawal are common, with the psychological burden being particularly pronounced among candidates for heart and lung transplantation. The persistence of these symptoms and their impact on treatment adherence are highly relevant to clinical decision-making.

In the early post-transplant period, the most critical neuropsychiatric syndrome is postoperative delirium. Surgical complications, infections, metabolic disturbances, and especially immunosuppressive agents such as corticosteroids and calcineurin inhibitors may precipitate syndromes including mania, psychosis, delirium, and catatonia. Moreover, because these agents have narrow therapeutic indices and are metabolized via cytochrome P450 3A4 (CYP3A4), clinically significant interactions with psychotropic medications may emerge. Therefore, early recognition, careful management of drug–drug interactions, and a consultation-liaison psychiatry approach are integral components of treatment success (Heinrich & Marcangelo, 2009).

During long-term follow-up, depression, anxiety, post-traumatic stress symptoms, declining treatment adherence, and impaired quality of life may develop. Accordingly, transplant psychiatry should focus not only on acute complications but also on long-term psychosocial adaptation, which directly affects graft survival and overall functioning.

In conclusion, transplant psychiatry is a core clinical discipline that directly contributes to graft survival, quality of life, and family functioning through pre-transplant risk formulation, management of the psychological burden during the waiting-list period, recognition of early neuropsychiatric complications, and reinforcement of long-term treatment adherence.

References

1. Sarkar S, Grover S, Chadda RK (2022) Psychiatric assessment of persons for solid-organ transplant. Indian J Psychiatry 64 (Suppl. 2): S308-S318.
2. DiMartini AF, Sotelo JL, Dew MA (2011) Organ transplantation. Textbook of Psychosomatic Medicine, 2. Baskı, JL Levenson (Ed), Arlington, VA, The American Psychiatric Publishing, s. 725-758.
3. Heinrich TW, Marcangelo M (2009) Psychiatric issues in solid organ transplantation. Harv Rev Psychiatry 17: 398-406.

Is Good Intentions Enough? The Fine Boundaries Between Moralism and Ethical Stance in Psychiatry

Gamze Gürcan
TOBB University of Economics and Technology, Faculty of Medicine, Department of Psychiatry

Psychiatric practice, by its very nature, is situated in close proximity to ethical issues, and the clinician must possess not only technical expertise but also a well-developed ethical sensitivity. Clinical interaction often extends beyond the mere assessment of symptoms, intertwining with the individual's life values, beliefs, and social context. Within this framework, the commonly assumed notion of "good intentions" is often regarded as providing a sufficient ethical foundation for clinical decision-making. However, in recent years, it has been more explicitly argued that while good intentions are a necessary condition for an ethically sound stance, they are not sufficient on their own. This perspective necessitates an examination of the boundaries between moralism and ethical stance in psychiatry, as well as an evaluation of the conditions under which good intentions may give rise to ethical risks.

Moralism emerges when the clinician positions their own value judgments as universal truths and directs them toward the patient. This can undermine patient autonomy, particularly in clinical relationships where power asymmetry is pronounced, and may create a form of implicit coercion within the therapeutic process. In contrast, an ethical stance requires a balanced evaluation among the principles of respect for autonomy, nonmaleficence, beneficence, and justice, while taking into account the individual's own values. These principles are defined within the framework of the four-principles approach that forms the foundation of modern biomedical ethics and provides clinicians with a systematic structure for ethical evaluation.

Situations in which good intentions become ethically problematic are often associated with paternalistic tendencies that are difficult to detect. In clinical practice, the distinction between "wanting the best for the patient" and "making decisions on behalf of the patient" may become blurred. This ambiguity becomes even more apparent in contexts such as involuntary treatment, risk management, and cases marked by significant cultural differences. Therefore, ethical awareness must be supported not only by individual good intentions but also by structured ethical deliberation processes.

Clinical examples make visible the conditions under which good intentions may shift into moralism and their implications for patients' rights. In such cases, reflexivity—entailing the clinician's critical examination of their own position and influence—along with ethical consultation mechanisms, emerge as essential tools for mitigating potential risks. In conclusion, it becomes evident that an ethical psychiatric practice cannot be sustained by good intentions

alone; rather, it requires critical thinking, systematic evaluation grounded in ethical principles, and an awareness of power dynamics.

References

1. Beauchamp TL, Childress JF. Principles of Biomedical Ethics. 7th ed. New York: Oxford University Press; 2013.
2. Fulford KWM. Values-based practice: a new partner to evidence-based practice and a first for psychiatry? World Psychiatry 2008;7:10–12.
3. Gillon R. Ethics needs principles—four can encompass the rest—and respect for autonomy should be “first among equals”. J Med Ethics 2003;29:307–312.

Algorithms in Sexuality: Sex Chatbots and Sex Robots

Sena Akpolat
Ankara Bilkent City Hospital, Department of Psychiatry

In this era of rapid digitalization, sexuality has evolved beyond an exclusively interpersonal experience and has become a domain increasingly reconstructed through algorithms and artificial intelligence systems. Sex chatbots and sex robots represent some of the most visible manifestations of this transformation, enabling the reorganization of desire, attachment, and sexual gratification through technological mediation. By processing user data to generate personalized interactions, these systems are experienced not merely as passive tools but as interactive entities that learn and respond (Danaher, 2019; Döring & Poeschl, 2020).
Sex chatbots engage users in erotic interaction via text or voice using natural language processing techniques, whereas sex robots extend this interaction into a physical dimension. Both technologies function as adaptive systems that learn user preferences and optimize their responses accordingly. This process can be conceptualized within the framework of dopaminergic reward systems, particularly in terms of reward prediction error and reinforcement mechanisms. Continuous feedback and personalized stimulation may be associated with heightened “wanting” processes, the development of tolerance, and patterns resembling behavioral addiction, especially in vulnerable individuals (Kuss & Griffiths, 2017).
However, the impact of these technologies is not limited to the neurobiological level. From a psychodynamic perspective, sex chatbots and robots may facilitate the reconfiguration of object relations and attachment patterns on a novel surface. These “digital others,” which are shaped according to the user’s needs, non-rejecting, and continuously accessible, may align with idealized object representations and thereby serve a regulatory function for individuals with fragile self-structures. At the same time, this dynamic may contribute to reduced tolerance for frustration in real interpersonal relationships, as well as a weakening of reciprocity and boundary experiences.
While these technologies may provide a space that reduces social anxiety and facilitates sexual expression and exploration for some individuals, they also raise ethical and clinical concerns, including objectification, the redefinition of consent, and the blurring of reality boundaries. Therefore, sex chatbots and robots should be understood not merely as technological innovations, but as multi-layered phenomena situated at the intersection of reward systems, attachment processes, and cultural norms.
In conclusion, this field represents a transformation in which the boundaries between pleasure and control, intimacy and distance, and reality and simulation are being renegotiated. Accordingly, this phenomenon should not be reduced to a dichotomy of pathology versus

adaptation, but rather addressed within a comprehensive clinical and theoretical framework that encompasses both its risks and functional aspects.

References

1. Danaher J. (2019). The philosophical case for robot sex. In: Robot Sex: Social and Ethical Implications. MIT Press.
2. Döring N, Poeschl S. (2020). Experiences with diverse sex toys and sexual satisfaction. Journal of Sex Research, 57(7), 1–15. https://doi.org/10.1080/00224499.2019.1618294
3. Kuss DJ, Griffiths MD. (2017). Social networking sites and addiction: Ten lessons learned. International Journal of Environmental Research and Public Health, 14(3), 311. https://doi.org/10.3390/ijerph14030311

Treatment of Vaginismus:
From Systemic Formulation to Couple-Focused Intervention

Sinay Önen
University of Health Sciences, Bursa Faculty of Medicine, Department of Psychiatry

Vaginismus, currently classified under Genito-Pelvic Pain/Penetration Disorder (GPPPD), should be understood not only as a difficulty with vaginal penetration, but also as a condition shaped by fear, avoidance, pelvic floor tension, relational distress, and sociocultural meanings attached to sexuality. This presentation focuses on the treatment of vaginismus from a systemic perspective and argues that the symptom should be formulated not only at the level of the woman's body, but also within the couple's interactional system.

The systemic approach to sex therapy provides a useful framework for understanding vaginismus across five domains: individual biology, individual psychology, dyadic factors, family-of-origin issues, and sociocultural context. From this perspective, vaginismus may be maintained by pain-related fear, catastrophic expectations, shame, negative partner responses, poor sexual communication, family boundary problems, and cultural beliefs about virginity, penetration, and sexual performance. The fear-avoidance cycle is especially important, as painful or failed attempts at penetration may increase anxiety, reinforce avoidance, and contribute to repeated negative experiences.

Using the clinical case presented in the panel, this talk proposes a case-based couple formulation. In this case, the initial penetration difficulty became more severe in the context of family intrusion, performance pressure, shame, and boundary violations. These experiences appeared to intensify threat perception and avoidance in the woman, while also contributing to helplessness, withdrawal, and secondary sexual dysfunction in the male partner. Therefore, treatment should not begin with a narrow focus on intercourse itself. The first therapeutic aim is to establish safety, restore couple privacy, reduce family interference, and develop a shared understanding of the problem.

The later stages of treatment include psychoeducation, restructuring maladaptive partner responses, improving sexual communication, reducing shame and catastrophic beliefs, introducing non-demand pleasuring and sensate focus exercises, and using gradual exposure in a way that increases the woman's sense of control. A couple-focused and multidisciplinary approach may help reduce pain-related distress, improve sexual functioning, and strengthen relational adjustment. In this sense, effective treatment of vaginismus requires not only symptom reduction, but also reorganization of the couple system and recovery of a safe and private sexual space.

References

1. Hertlein KM, Nelson M (2017) A Systemic Approach to Sex Therapy. The Wiley Handbook of Sex Therapy, ZD Peterson (Ed), Chichester, John Wiley & Sons, s. 202-217.
2. Rosen NO, Bergeron S (2019) Genito-pelvic pain through a dyadic lens: Moving toward an interpersonal emotion regulation model of women's sexual dysfunction. J Sex Res 56: 440-461.
3. Bergeron S, Vaillancourt-Morel MP, Corsini-Munt S ve ark. (2021) Cognitive-behavioral couple therapy versus lidocaine for provoked vestibulodynia: A randomized clinical trial. J Consult Clin Psychol 89: 316-326.

Female Sexual Interest/Arousal Disorder:
Understanding the What, Why, and How of Clinical Practice

Canan Efe

Sexuality is influenced by biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious, and spiritual factors. The etiology of female sexual interest and arousal disorder (FSIAD) is likewise a clinical condition in which multiple physiological, psychological, and social factors play a significant role. It is affected by endocrinological diseases, vascular and neurological disorders, surgical procedures, chronic systemic diseases, anxiety disorders, depression and other sexual dysfunctions, as well as other psychopathologies, medications used for psychiatric treatment, medications used for general medical conditions, and psychosocial factors. Among psychosocial factors, cultural characteristics, upbringing, religious beliefs, socioeconomic status, partner relationship problems, and age are all important contributors.

There is currently insufficient research on the relationship between FSIAD and other mental illnesses. However, based on available evidence, it is known to co-occur with a range of psychiatric conditions — most notably depression, anxiety disorders, other sexual dysfunctions, alcohol and substance use disorders, and post-traumatic stress disorder. This relationship is bidirectional: individuals experiencing FSIAD may develop secondary psychopathology as a consequence, or conversely, FSIAD may emerge as a manifestation of an underlying mental illness. Shared mechanisms of action and overlapping diagnostic criteria may be cited among the reasons for this co-occurrence.

It is well established that medications used in the treatment of psychiatric disorders carry sexual side effects. Antidepressants — particularly SSRIs — as well as antipsychotics, mood stabilizers, anticholinergics, and antihistamines can cause sexual dysfunction through various pathways. It is essential to determine whether the presenting condition is attributable to the illness itself or represents a secondary, medication-induced effect. Treatment should be planned and adjusted only after this distinction has been clearly established

References

1. Perelman, M. A. (2023). Helen Singer Kaplan's Sexual Response Models and Legacy. Encyclopedia of Sexuality and Gender. Springer, Cham. https://doi.org/10.1007/978-3-319-59531-3_79-1.

2. TAŞDELEN, R. (2023). Kadınlarda Cinsel Yaşam ve Cinsel İşlev Bozuklukları. Turkiye Klinikleri Psychiatry-Special Topics, 16(2), 14-22.
3. DİLCİ, D. G. T., & GÜLEÇ, G. (2025). Psikiyatrik Bozukluklar ve Eşlik Eden Cinsel Bozukluklar. Turkiye Klinikleri Psychiatry-Special Topics, 18(1), 76-86.
4. Basson, R. O. S. E. M. A. R. Y. (2007). Sexual desire/arousal disorders in women. Principles and practice of sex therapy, 4, 25-53.

Contemporary Perspective On Body Dysmorphic Disorder

N. Serkut Bulut
Department of Psychiatry, Marmara University Faculty of Medicine, Pendik Training and Research Hospital, Istanbul, Türkiye

Body Dysmorphic Disorder (BDD) is a psychiatric condition characterized by an intense preoccupation with perceived defects or flaws in physical appearance that are typically not noticeable or are considered minor by others. These preoccupations lead to significant distress and functional impairment, adversely affecting social, academic, and occupational functioning. Although BDD is more prevalent among adolescents and young adults than commonly assumed, it is frequently overlooked in clinical practice, resulting in delays in appropriate diagnosis and treatment.

Appearance-related obsessions in BDD are often accompanied by repetitive behaviors and mental acts, such as mirror checking, camouflaging perceived defects, and seeking reassurance from others. In addition, avoidance behaviors -such as withdrawing from social interactions, avoiding online communication, or, in severe cases, remaining housebound- are commonly observed. A notable feature of BDD is the variability in insight; while some individuals recognize the excessive nature of their concerns, others hold these beliefs with delusional conviction.

Epidemiological data suggest that the prevalence of BDD in the general population is approximately 2–2.5%, with substantially higher rates reported in clinical samples. BDD frequently co-occurs with other psychiatric disorders, including Obsessive-Compulsive Disorder (OCD), depressive disorders, social anxiety disorder, and eating disorders. Importantly, BDD is associated with elevated rates of suicidal ideation and self-harming behaviors.

From an etiological perspective, BDD appears to arise from the interaction of genetic vulnerability and environmental factors, including childhood trauma, peer bullying, and sociocultural influences. In particular, the widespread use of social media and the promotion of idealized body images are considered significant contributors to appearance-related concerns in young individuals.

A thorough clinical interview remains the cornerstone of diagnosis, with psychometric instruments serving as supportive tools. Evidence-based treatment approaches primarily include Cognitive Behavioral Therapy (CBT) and Selective Serotonin Reuptake Inhibitors (SSRIs). Early recognition and timely intervention are crucial for improving functional outcomes and reducing the risk of suicide. This review aims to enhance clinicians' awareness by summarizing the clinical features, etiology, and current treatment approaches of BDD.

References

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (Fifth, Text Revision Ed.). Washington DC: American Psychiatric Association Publishing; 2022.
2. Angelakis I, Gooding PA, Panagioti M. Suicidality in body dysmorphic disorder (BDD): A systematic review with meta-analysis. Clin Psychol Rev 2016; 49: 55-66.
3. Krebs G, Clark BR, Ford TJ, Stringaris A. Epidemiology of body dysmorphic disorder and appearance preoccupation in youth: prevalence, comorbidity and psychosocial impairment. J Am Acad Child Adolesc Psychiatry 2025; 64(1): 30-40.

Hacking Sexuality: The Culture of Chemsex

Tayfun Özbek
Ankara Bilkent City Hospital, Department of Psychiatry

Chemsex is fundamentally defined as the strategic use of psychoactive substances—predominantly mephedrone, GHB/GBL, and crystal methamphetamine—before or during sexual encounters to sustain, intensify, or facilitate the experience and reduce psychological inhibitions. While these substances form the core of the practice, clinical literature also discusses the involvement of ketamine and cocaine within this expanding framework (Bourne et al. 2015, Weatherburn et al 2017). However, chemsex is not merely a behavioral pattern dictated by the pharmacological properties of drugs. It represents a complex cultural landscape where traditional notions of desire, performance, privacy, and bodily boundaries are being fundamentally reconfigured. Therefore, it is essential to analyze chemsex not just as "risky substance use," but as a distinct and multifaceted manifestation of contemporary sexual culture (Maxwell et al. 2019, Weatherburn et al. 2017).

The organization of chemsex is intrinsically linked to digital infrastructure. Geosocial dating applications and instant messaging networks facilitate more than just partner selection; they enable the coordinated planning of substance acquisition, physical space, and the nature of the sexual encounter itself. This digital integration elevates chemsex from an individual action into a structured subcultural practice defined by its own unique lexicon, norms, symbols, and rituals (Maxwell et al. 2019). Qualitative research indicates that in specific urban environments, chemsex is perceived as a normative experience, which significantly dictates individual expectations and motivations for participation.

The allure of this culture extends beyond the promise of heightened hedonism. For many individuals, chemsex functions as a psychological "hack" to mitigate social anxiety, suspend the fear of rejection, and alleviate the pervasive pressure of sexual performance, fostering a more "fluid" experience of the self (Bourne et al. 2015). Conversely, this environment introduces significant clinical vulnerabilities. Factors such as inadequate dosing knowledge, prolonged sessions, multiple partners, and memory blackouts lead to severe physical exhaustion and complex dilemmas regarding informed consent (Bourne et al. 2015). Systematic reviews emphasize that chemsex is linked to adverse psychiatric outcomes, including depressive symptoms, anxiety, and compulsive use patterns. Ultimately, chemsex remains a phenomenon where liberation and loss of control converge.

References

1. Bourne A, Reid D, Hickson F, Torres-Rueda S, Steinberg P, Weatherburn P. (2015). “Chemsex” and harm reduction need among gay men in South London. International Journal of Drug Policy, 26(12), 1171–1176. https://doi.org/10.1016/j.drugpo.2015.07.013
2. Maxwell S, Shahmanesh M, Gafos M. (2019). Chemsex behaviours among men who have sex with men: A systematic review of the literature. International Journal of Drug Policy, 63, 74–89. https://doi.org/10.1016/j.drugpo.2018.11.014
3. Weatherburn P, Hickson F, Torres-Rueda S, Reid D, Bourne A. (2017). Social norms related to combining drugs and sex (“chemsex”) among gay men in South London. International Journal of Drug Policy, 38, 29–35. https://doi.org/10.1016/j.drugpo.2016.10.007

Methodological Comparison and Critical Evaluation of the Adult Mental Health Profile Studies in Türkiye: 1998 vs. 2023

Özge Şahmelikoğlu Onur
Tekirdağ Namık Kemal University, Faculty of Medicine, Department of Psychiatry

This presentation aims to provide a comparative and critical methodological evaluation of two large-scale epidemiological studies conducted in Türkiye: the Adult Mental Health Profile studies of 1998 (RSP-1) and 2023 (RSP-2). The two studies were compared in terms of sampling strategies, inclusion and exclusion criteria, assessment instruments, interviewer characteristics, training procedures, and data collection methods. RSP-1 utilized a broader set of instruments including CIDI-1, the General Health Questionnaire, and the Brief Disability Questionnaire, while RSP-2 employed a modified version of CIDI-5 with certain diagnostic modules removed or shortened. Differences in sample size, field procedures, and technological integration were also examined. RSP-1 included a larger sample (n=7479) and adopted a more comprehensive assessment approach, covering a wider range of psychiatric conditions and functional outcomes. In contrast, RSP-2 had a smaller sample (n=2375) but employed more standardized and technologically supported data collection procedures, including tablet-based interviews and centralized training systems. The use of TÜİK-based stratified cluster sampling in RSP-2 improved representativeness, while stricter inclusion criteria resulted in a more homogeneous sample. However, the exclusion or reduction of certain diagnostic modules suggests a narrowing of scope. Despite their significant contributions to psychiatric epidemiology in Türkiye, both RSP-1 and RSP-2 present important methodological limitations that should be considered when interpreting their findings. A central issue concerns the trade-off between scope and standardization. RSP-1 provides a more comprehensive assessment, including a broader range of psychiatric conditions and functional outcomes. However, this extensive scope may have increased respondent burden and introduced variability in data quality. In contrast, RSP-2 adopts a more standardized and streamlined design, enhancing feasibility and internal consistency, yet at the cost of excluding key diagnostic domains such as psychotic disorders and personality traits. This reduction limits the overall epidemiological comprehensiveness. Another critical limitation involves comparability across time. The use of different diagnostic instruments (CIDI-1 vs. CIDI-5), along with structural modifications and evolving diagnostic criteria, raises concerns about measurement invariance. Consequently, observed differences between the two studies may reflect methodological discrepancies rather than true changes in prevalence, complicating longitudinal interpretations. Differences in sample size and composition also warrant attention. While RSP-1 benefits from a larger sample size, RSP-2 relies on a smaller but

more systematically selected sample based on national statistical data. Although this approach may improve representativeness, the reduced sample size may limit statistical power, particularly for low-prevalence disorders. Additionally, stricter inclusion criteria in RSP-2 may have resulted in the exclusion of vulnerable populations, such as non-citizens and non-Turkish speakers, thereby introducing potential selection bias. The interviewer effect represents another source of potential bias. In RSP-1, interviews conducted by physicians may have introduced subjective clinical judgment, whereas in RSP-2, non-clinician interviewers, despite standardized training, may lack the clinical sensitivity required for identifying complex psychiatric presentations. Finally, although the integration of digital tools in RSP-2 enhances data quality and standardization, it may also introduce new forms of bias related to technological accessibility and participant comfort, particularly among older or less educated populations.

References

1. Neşe Erol, Cengiz Kılıç, Mahir Ulusoy, Muzaffer Keçeci, Zeynep Şimşek, TÜRKİYE RUH SAĞLIĞI PROFİLİ RAPORU, 1998.
2. Cengiz KILIÇ, Bedirhan Üstün, Mahir Ulusoy, Özlem Şeyda Uluğ, Sertaç Ak, Emine Eren Koçak, Özge Çaman, Songül Kamışlı, Türkiye Ruh Sağlığı Profili Araştırması - 2 SONUÇ RAPORU, 2023.

Evidence-Based Psychotherapeutic Treatments in Obsessive-Compulsive Disorder

Ali Ercan Altınöz
Eskişehir Osmangazi University Faculty of Medicine, Department of Psychiatry

Obsessive-Compulsive Disorder (OCD) is a chronic and potentially disabling psychiatric condition characterized by the presence of intrusive, distressing thoughts known as obsessions and repetitive behaviors or mental acts termed compulsions. These symptoms often lead to significant functional impairment and a diminished quality of life. According to international clinical guidelines, psychotherapeutic interventions, particularly those categorized under Cognitive Behavioral Therapy (CBT), are established as first-line treatments for patients across all age groups. This presentation aims to provide a comprehensive review of current evidence-based psychotherapeutic modalities for OCD, focusing on their theoretical foundations, mechanisms of action, and clinical efficacy.

Exposure and Response Prevention (ERP) remains the gold standard of behavioral interventions for OCD. It involves systematic exposure to anxiety-provoking stimuli while strictly refraining from performing ritualistic behaviors, thereby facilitating inhibitory learning and habituation. Cognitive Therapy (CT) complements this by targeting the catastrophic misinterpretations of intrusive thoughts and the overestimation of threat, utilizing cognitive restructuring techniques to modify dysfunctional beliefs. Furthermore, Metacognitive Therapy (MCT) has emerged as a significant development in the field. Unlike traditional cognitive models that focus primarily on the content of thoughts, MCT addresses the metacognitive processes—specifically "thinking about thinking"—and targets beliefs such as thought-event fusion and the perceived necessity of controlling one’s cognitive processes.

The successful implementation of these therapies requires a meticulous clinical assessment. Critical factors such as patient motivation, the presence of comorbid conditions—including Major Depressive Disorder (MDD) or Attention-Deficit/Hyperactivity Disorder (ADHD)—and the evaluation of suicide risk must be integrated into the treatment planning. Recent meta-analytic studies consistently demonstrate that these structured psychotherapeutic approaches yield high effect sizes in symptom reduction and substantial improvements in overall functioning. In conclusion, providing a personalized treatment plan that incorporates these evidence-based techniques is vital for achieving long-term recovery. This presentation will synthesize these therapeutic frameworks to offer clinicians practical insights for managing OCD within a contemporary evidence-based framework.

References

1. World Health Organization. International Statistical Classification of Diseases and Related Health Problems. 11th ed. Geneva: World Health Organization; 2024.
2. Hirschtritt ME, Bloch MH, Mathews CA. Obsessive-compulsive disorder: Advances in diagnosis and treatment. JAMA 2017; 317(13): 1358-67.
3. Wells A. Metacognitive Therapy for Anxiety and Depression. New York: Guilford Press; 2011.

Rethinking Professional Ethics in Psychiatry: A Discussion of the Tension Between Preserving Ethical Principles and Avoiding the Reproduction of Power Asymmetry

Sibel Koçbıyık

Unlike other medical specialties, psychiatry is not limited to diagnosing and treating illness; it also evaluates behavior, normality, risk, decision-making capacity, and social functioning. For this reason, psychiatric interventions do not produce only clinical outcomes; they may also affect a person's liberty, social status, legal standing, and sense of self. This makes it necessary to reconsider psychiatric ethics not only within the framework of classical medical ethics, but also in relation to power.

This presentation aims to discuss professional ethics in psychiatry through the tension between preserving ethical principles and avoiding the reproduction of power asymmetries. First, it examines why the core principles of medical ethics—beneficence, nonmaleficence, respect for autonomy, and justice—are not sufficient on their own in psychiatry, and how they must be expanded through psychiatry-specific concerns such as epistemic responsibility, value-ladenness, and role ethics. Second, it explores why the relationship between psychiatrist and patient is structurally asymmetrical, focusing on diagnosis, risk assessment, involuntary hospitalization, the limits of confidentiality, and evaluations that may have legal consequences. In this context, particular attention will be given to the concept of epistemic injustice and to the ways in which the patient's account can easily be reduced to symptomatology.

Finally, the presentation analyzes how the tension between ethical principles and power emerges at clinical, institutional, and social levels. Drawing on examples from forensic psychiatry, dual loyalty, paternalism, boundary violations, and the political misuse of psychiatry, it argues that ethical reflection in psychiatry is not simply a matter of choosing the "right" principle. Rather, it also requires examining the power relations within which psychiatric knowledge, authority, and intervention are produced. The central claim of the presentation is that to act ethically in psychiatry is not only to defend ethical principles, but also to sustain a critical awareness that prevents those very principles from becoming instruments of domination.

The Future of Desire: Digital Evolution and a Psychodynamic Perspective of Sexuality

Şiirnaz Kükürt[1]
[1]Department of Psychiatry, Bezmialem Vakıf University Hospital, Istanbul, Türkiye

The rapid advancement of artificial intelligence and the increasing digitalisation of everyday life are fundamentally transforming human desire by shifting it from a corporeal plane to algorithmic interfaces, thereby redefining the very concept of intimacy. This presentation aims to analyse the impact of digital partners and algorithmic matching systems on the individual psyche from a psychodynamic perspective.

Contemporary digital platforms offer highly controllable, continuously accessible simulations of relationships that minimise the risk of rejection. Döring and Pöschl (2018) emphasise that forms of digital intimacy represent not merely a technological innovation but also a structural transformation in the dynamics of desire and attachment (1). This transformation appears particularly appealing to individuals with heightened attachment anxiety and narcissistic vulnerability. Within this framework, the presentation will explore the hypothesis that such algorithmic structures may assume a function analogous to the “transitional object” as conceptualised by Donald Winnicott (1953) (2). These digital objects, which mediate between internal and external reality, may alleviate separation anxiety in the short term; however, in the long term, they risk evolving into substitute relational systems that replace authentic engagements with the unpredictable and potentially frustrating reality of the other.

Over time, the individual’s preference for controlled digital environments over uncertain real-world interactions may trigger a self-reinforcing “cycle of digital isolation”: the digital comfort zone reinforces social avoidance, while diminished interpersonal engagement further increases reliance on digital objects. Consequently, this presentation raises the critical question of whether algorithmic forms of intimacy constitute a “new norm” or function as a clinical “defence mechanism.” Recognising these emerging forms of desire in clinical practice is essential for redefining the boundaries of psychopathology and updating mental health interventions in the digital age.

References

1. Döring N, Pöschl S. Love and sex with robots: A content analysis of media representations. Int J Soc Robot. 2018
2. Winnicott DW. Transitional objects and transitional phenomena. Int J Psychoanal. 1953

Psycho-Oncology in Practice: Patient- and Family-Based Psychotherapeutic Approaches

Emir Arif Erten
Sincan Teachig and Research Hospital, Ankara

Psycho-oncology is a subspecialty that examines the emotional responses of cancer patients and their families to illness, and the psychological, behavioral, and social factors that may influence the cancer process. Emerging in the late 1970s alongside improvements in cancer survival rates and a gradual reduction in social silence surrounding the disease, this field was formally established in the United States in the early 1990s. Today, it promotes collaborative care models that integrate psychiatrists, psychologists, and family members alongside oncologists.

Cancer diagnosis confronts individuals and families with a wide array of psychosocial challenges. The most pervasive of these is a profound sense of uncertainty that persists throughout the illness trajectory. Patients frequently experience identity loss, body image disturbances, social isolation, existential crises, and feelings of guilt and stigmatization (Breitbard ve ark. 2021). The concept of "Damocles Syndrome" describes the lingering psychological shadow of potential recurrence among cancer survivors, while "survivor loneliness" reflects the alienation felt when patients perceive themselves as fundamentally different from their healthy peers. These difficulties extend beyond the individual; the stress experienced by patients and caregivers is mutually regulated, making the entire family system a target for psychotherapeutic intervention(Holland ve ark. 2000).

Psycho-oncology draws on a broad repertoire of evidence-based psychotherapeutic tools. Psychoeducation provides structured information about diagnosis, treatment, and emotional responses, thereby reducing uncertainty-driven anxiety and improving treatment adherence. Behavioral interventions -including relaxation training, behavioral activation, and activity pacing- target depression, fatigue, and sleep disturbances. Cognitive behavioral therapy (CBT) is the most extensively researched modality in this population and addresses maladaptive cognitions, helplessness, and disease-specific concerns such as insomnia and procedure-related anxiety (2). Acceptance and Commitment Therapy (ACT) aims not to eliminate distressing thoughts but to alter the patient's relationship with them, promoting psychological flexibility through acceptance, defusion, and values-based action. Metacognitive Therapy (MCT) specifically targets rumination and the unhelpful monitoring of threat-related thoughts, particularly fear of recurrence. Supportive psychotherapy, rooted in psychodynamic principles, creates a "holding environment" that respects adaptive defense mechanisms and sustains realistic hope across critical illness transitions(Breitbart ve ark. 2021).

Existential approaches — including Meaning-Centered Psychotherapy (MCP), derived from Viktor Frankl's Logotherapy, and Dignity Therapy — address the loss of meaning, existential guilt, and death anxiety that frequently arise in advanced illness. These therapies reinforce the belief that meaning-making remains possible until the final moments of life, encouraging patients to connect with their legacy, values, and relational bonds. Couple- and family-based interventions (e.g., CanCOPE, Cognitive-Existential Couple Therapy, Emotion-Focused Couples Therapy, Family-Focused Grief Therapy) address the interdependent distress of patients and their close relatives, targeting communication deficits, intimacy disruption, and complicated grief (3). The selection of any psychotherapeutic approach must be individualized, guided by the patient's personality, coping style, illness stage, clinical symptoms, and personal preferences(Breitbart ve ark. 2014).

References

1. Breitbart, W., Butow, P., Jacobsen, P., Lam, W., Lazenby, M., & Loscalzo, M. (Eds.). (2021). Psycho-oncology (pp. 385–573). Oxford University Press.
2. Breitbart W, Poppito S. Meaning-Centered Group Psychotherapy for Patients with Advanced Cancer: A Treatment Manual. Oxford: Oxford University Press; 2014.
3. Holland, J. C., & Lewis, S. (2000). The human side of cancer: Living with hope, coping with uncertainty (Vol. 12). New York: HarperCollins.

Commercialization of Psychiatric Knowledge: Personal Branding, Sponsorships, and Conflicts of Interest

Nehir Kürklü

The rapid expansion of digital platforms has transformed the role of psychiatrists from solely clinical practitioners into visible public communicators. Social media enables the dissemination of mental health information to broad audiences, contributing to increased awareness and accessibility. However, this transformation has also introduced new ethical challenges, particularly regarding the commercialization of psychiatric knowledge.

Commercialization refers to the process through which professional knowledge is transformed into economic value. In the context of psychiatry, this may include online consultations, subscription-based psychoeducational content, digital courses, and collaborations with commercial entities. While such practices can enhance access to mental health resources, they also blur the boundaries between clinical responsibility and market-driven behavior.

Personal branding has become a central component of digital visibility. Psychiatrists increasingly construct online identities that extend beyond their clinical roles. Metrics such as follower counts and engagement rates may influence perceived credibility, potentially shifting trust from evidence-based expertise toward popularity. This shift raises concerns about the prioritization of visibility over scientific accuracy.

Sponsorships and partnerships with digital mental health applications and wellness industries further complicate this landscape. Although not inherently problematic, these relationships may introduce conflicts of interest (COI), defined as situations in which professional judgment concerning a primary interest (such as patient welfare or scientific integrity) may be influenced by a secondary interest (such as financial gain). Lack of transparency in sponsored content can undermine trust and compromise ethical standards.

These dynamics also affect patients. Exposure to simplified or generalized psychiatric content may lead individuals to self-diagnose or develop unrealistic expectations regarding treatment processes. Consequently, the therapeutic relationship may be influenced before clinical contact is established.

In conclusion, while digital engagement is an inevitable and potentially beneficial aspect of

contemporary psychiatric practice, it necessitates careful ethical consideration. Transparency, adherence to evidence-based practice, and clear professional boundaries are essential to maintaining the integrity of psychiatric knowledge in the digital age.

References

1. American Psychiatric Association. The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry. Washington DC: American Psychiatric Association; 2013.
2. World Health Organization. Ethics and governance of artificial intelligence for health. Geneva: WHO; 2021.
3. Ventola CL. Social media and health care professionals: benefits, risks, and best practices. P T. 2014;39(7):491–520.

Medical Cannabis in Psychiatric Patients: Evidence, Risks, and Interactions with Psychotropic Medications

Duygu Kılıçaslan
Başakşehir Çam and Sakura City Hospital, Department of Psychiatry, İstanbul, Turkey

The use of medical cannabis has increased substantially in recent years, driven by changing legal regulations and growing public interest. As a result, psychiatrists are increasingly confronted with patients using cannabis for both medical and non-medical purposes. This presentation aims to provide a clinically oriented synthesis of current evidence on the psychiatric effects of cannabis, with a particular focus on risks, therapeutic potential, and drug interactions.
Cannabis contains multiple active compounds, most notably Δ9-tetrahydrocannabinol (THC) and cannabidiol (CBD). THC is the primary psychoactive component and has consistently been associated with adverse psychiatric outcomes. Accumulating evidence indicates that cannabis use is linked to an increased risk of psychosis, earlier onset of psychotic disorders, and significantly higher relapse rates in individuals with established psychotic illness. In mood disorders, cannabis use is associated with greater symptom burden, poorer functional outcomes, and an overall worse clinical trajectory. Although some individuals report short-term anxiolytic effects, particularly with CBD, the available evidence supporting its efficacy in anxiety disorders remains limited, heterogeneous, and insufficient for routine clinical application.
CBD has attracted increasing interest due to its potential anxiolytic and antipsychotic properties. However, current data remain preliminary and do not justify its widespread use in psychiatric practice. Importantly, both THC and CBD can interact with psychotropic medications via cytochrome P450 (CYP) enzyme systems, particularly CYP3A4, CYP2C9, and CYP2C19. These interactions may lead to clinically meaningful alterations in drug exposure, increasing the risk of adverse effects, toxicity, and treatment instability.
Clinically relevant case reports further underscore these risks. Co-administration of CBD with selective serotonin reuptake inhibitors (SSRIs) may increase drug levels and lead to complications such as hyponatremia. Additionally, smoking cessation in patients treated with clozapine or olanzapine may result in a rapid increase in drug concentrations due to reduced CYP1A2 induction, potentially leading to toxicity.
In conclusion, the perception of cannabis as a “safe” or “natural” therapeutic option is not supported by current psychiatric evidence. While CBD may represent a future therapeutic avenue, THC-containing products are consistently associated with clinically significant risks. In psychiatric populations—particularly those receiving psychotropic medications—cannabis use

should be regarded as a relevant clinical risk factor rather than a benign intervention. A cautious, individualized, and systematically informed approach is essential in all clinical settings.

References

1. Groening JM, et al. Psychiatry Res 2024;331:115626.
2. Han K, et al. Psychiatry Res 2024;339:116049.
3. Chrobak AA, et al. Front Pharmacol 2024;15:1500312.

First-Generation Theories of Suicide

Gülşen Teksin
Tekirdag Namık Kemal University, Department of Mental Health and Disorders

The earliest systematic models developed to scientifically explain suicidal behavior are conceptualized within the scope of first-generation theories, which form the foundation of the contemporary biopsychosocial approach. Rather than explaining suicidal behavior solely through individual psychopathology, these theories address it within the context of the interaction among social, cultural, and psychological processes. The most prominent representative of this approach is Durkheim. Durkheim conceptualized suicide not as an individual pathology, but as a sociological phenomenon associated with levels of social integration and social regulation (Durkheim, 1897/1951). Through the classification of egoistic, altruistic, anomic, and fatalistic types of suicide, he demonstrated that both the weakening and the excessive strengthening of social bonds may increase suicide risk.

Within psychoanalytic theory, Freud explained suicidal behavior through the concept of aggression directed inward, proposing that in melancholia, aggression is redirected toward the self as a result of identification with the lost object (Freud, 1917). This approach was later expanded by Menninger, who argued that suicidal behavior represents a combination of the wish to kill, the wish to be killed, and the wish to die (Menninger, 1938). Psychoanalytic models emphasized the role of guilt, self-esteem, and superego functioning in suicidal behavior. Shneidman proposed that the central component of suicidal behavior is the individual's experience of unbearable psychological pain and introduced the concept of "psychache" into the literature (Shneidman, 1985, 1993). By placing the individual's subjective experience at the center of analysis, this perspective made a significant contribution to the development of modern cognitive theories. Expanding the sociological perspective, Henry and Short argued that social frustration determines the direction of aggression and that suicide risk increases when aggression is directed toward the self (Henry & Short, 1954). The "presuicidal syndrome," described by Ringel, refers to a process characterized by repressed aggression and suicidal fantasies (Ringel, 1976).

A common feature of first-generation theories is their consideration of suicidal behavior as a multidimensional phenomenon. However, the limited number of empirically testable models and the insufficient consideration of neurobiological variables are regarded as significant limitations. Nevertheless, these theories have provided an important conceptual foundation for the development of modern suicide theories, particularly interpersonal and cognitive models,

and have played a determining role in the historical evolution of the biopsychosocial approach (Lester, 1997; O'Connor & Nock, 2014; Turecki & Brent, 2016).

References

1. Durkheim, E. (1951). Suicide: A study in sociology (J. A. Spaulding & G. Simpson, Trans.; G. Simpson, Ed.). New York, NY: Free Press. (Original work published 1897).
2. Freud, S. (1917). Mourning and melancholia. In J. Strachey (Ed. & Trans.), The standard edition of the complete psychological works of Sigmund Freud (Vol. 14, pp. 237–258). London: Hogarth Press.
3. Henry, A. F., & Short, J. F., Jr. (1954). Suicide and homicide: Some economic, sociological, and psychological aspects of aggression. Glencoe, IL: Free Press.
4. Lester, D. (1997). Theories of suicide. Philadelphia, PA: Taylor & Francis.
5. Menninger, K. A. (1938). Man against himself. New York, NY: Harcourt, Brace.
6. O'Connor, R. C., & Nock, M. K. (2014). The psychology of suicidal behaviour. The Lancet Psychiatry, 1(1), 73–85.
7. Ringel, E. (1976). The presuicidal syndrome. Suicide and Life-Threatening Behavior, 6(3), 131–149.
8. Shneidman, E. S. (1985). Definition of suicide. New York, NY: Wiley.
9. Shneidman, E. S. (1993). Suicide as psychache: A clinical approach to self-destructive behavior. Northvale, NJ: Jason Aronson.
10. Turecki, G., & Brent, D. A. (2016). Suicide and suicidal behaviour. The Lancet, 387(10024), 1227–1239.

The Narrative of War: When Do Trauma, Grief, and Meaning Heal — and When Do They Wound?

Süleyman Çankaya
Department of Psychiatry, Faculty of Medicine, Bolu Abant İzzet Baysal University

War is an experience capable of inflicting profound wounds upon individual and collective psyche, fragmenting the sense of continuity and decimating the individual's meaning-making world. War narratives, on the one hand, may prepare the ground for recovery by integrating shattered experiences; on the other, when poorly constructed or instrumentalized for ideological purposes, they risk chronifying trauma and transforming it into a wound that persists across generations.

Trauma is, by its very nature, prelinguistic and resistant to symbolization. As Bessel van der Kolk underscores, "The Body Keeps the Score" — yet the mind struggles to organize this terror into a chronological and coherent narrative. Experiences within the chaos of war are encoded as fragmented images and somatic sensations, accompanied by the functional inhibition of language-processing regions such as Broca's area. Judith Herman posits that recovery becomes possible only when these fragmented traumatic memories are verbalized within a safe therapeutic relationship and coherently integrated into the individual's life narrative. However, when this narration occurs without adequate stabilization and the establishment of safety, it may re-expose the individual to the moment of horror, precipitating secondary traumatization. At this juncture, the narrative may cease to function as a healing bridge and instead become a perpetual trigger that keeps the psychological wound open.

The mourning process constitutes the most fundamental pathway through which the concrete and abstract losses brought about by war are processed. In Vamık Volkan's formulation, "Our mourning is as personal as our fingerprints." Mourning that is suppressed or obstructed in the aftermath of war may, at the societal level, consolidate into chosen traumas transmitted across generations. When shared narratives assume a structure that continually reactivates a group's sense of victimhood, dehumanizes the other, and perpetuates the impulse for revenge, they no longer serve to restore the meaning-making world but instead legitimize new cycles of violence — functioning as a wound in their own right. Conversely, mourning that is adequately processed facilitates the acceptance of loss as reality and enables the reconstruction of life around renewed meaning and values.

As Viktor Frankl articulates in Man's Search for Meaning, the human being is capable of preserving psychological integrity even in the face of the most severe adversity, provided that meaning can be found. A war narrative is therapeutically constructive when it affords the

individual a response to the question "Why me?" — one that is not destructive, but rather strengthens one's sense of agency and subjectivity. In the panel, the pathways through which the patient's trauma narrative may be transformed in clinical practice — moving from a passive, victim-centered account to an active narrative of survival and meaning construction — will be discussed. In conclusion, the war narrative may function as a balm when it serves the purpose of mourning the past and building a reparative future; conversely, it may present as a wound that never heals when it sustains identity conflicts and nourishes hatred.

Cognitive Functioning in Bipolar Disorder: Definitions, Core Concepts, and Assessment Tools

Ece Özlem Öztürk
Trabzon Kanuni Training and Research Hospital, Department of Psychiatry

Neuropsychology examines the relationship between the structural and functional properties of the brain and cognitive, emotional, and behavioral processes. In the context of bipolar disorder (BD), conceptualizations of cognitive functioning have undergone a substantial paradigm shift. The classical Kraepelinian view posited that cognitive functions remain intact during interictal periods and are only transiently impaired during acute mood episodes. However, contemporary neurodynamic models have challenged this assumption, suggesting a more persistent and heterogeneous pattern of impairment.

Current frameworks conceptualize cognitive dysfunction in BD within a “trait–state–scar” model. Acute manic and depressive episodes are associated with state-dependent, reversible cognitive impairments, whereas a core trait-like deficit persists even during euthymia. Additionally, recurrent mood episodes may exert cumulative neurotoxic effects in a subset of patients, leading to progressive neurocognitive decline, conceptualized as a “scar” effect (Van Rheenen et al., 2020; Keramatian et al., 2021).

Neurobiologically, cognitive deficits in BD have been linked to structural and functional alterations in prefrontal cortical regions, the hippocampus, and fronto-striatal networks. Clinically, euthymic patients often perform within normative limits on simple cognitive tasks; however, as task complexity increases, deficits become more apparent, particularly in executive functioning, verbal memory, and processing speed domains (Keramatian et al., 2021).

Pharmacological treatments may also exert differential effects on cognition. Lithium has been associated with neuroprotective properties and potential increases in gray matter volume, whereas certain anticonvulsants (e.g., topiramate) and antipsychotics may negatively impact processing speed and lexical retrieval. Another key clinical challenge is the discrepancy between subjective cognitive complaints and objective neuropsychological performance. Approximately 30–50% of euthymic patients report significant cognitive difficulties despite normative test performance, often associated with residual depressive symptoms and negative self-appraisal. Conversely, patients with impaired insight, frequently related to frontal network dysfunction, may underestimate or deny objective deficits (Jensen et al., 2015).

Given these complexities, current clinical guidelines emphasize the integration of both subjective and objective cognitive assessments. The International Society for Bipolar Disorders (ISBD) recommends routine cognitive screening even during euthymia. Tools such as the Screen

for Cognitive Impairment in Psychiatry (SCIP) and the Cognitive Complaints in Bipolar Disorder Rating Assessment (COBRA) provide complementary perspectives and enhance clinical utility. In conclusion, achieving functional recovery in BD requires more than mood stabilization. A multidimensional treatment approach incorporating systematic cognitive assessment, pharmacological optimization, and cognitive remediation strategies is essential for improving long-term outcomes.

References

1. Jensen J, Støttrup M, Nayberg E, et al. (2015) Optimising screening for cognitive dysfunction in bipolar disorder: Validation and evaluation of objective and subjective tools. J Affect Disord 187: 10–19.
2. Keramatian K, Torres IJ, Yatham LN (2021) Neurocognitive functioning in bipolar disorder: What we know and what we don't. Dialogues Clin Neurosci 23: 29–38.
3. Van Rheenen TE, Lewandowski KE, Bauer IE, et al. (2020) Current understandings of the trajectory and emerging correlates of cognitive impairment in bipolar disorder: An overview of evidence. Bipolar Disord 22: 13–27.

From Neurobiological Foundations to Cognitive Behavioral Therapy Applications in Adult Attention Deficit Hyperactivity Disorder

Özgür Değirmenci
Ege University, School of Medicine, Department of Psychiatry

Adult Attention Deficit and Hyperactivity Disorder (ADHD) is a complex neurodevelopmental disorder that goes beyond mere distraction and impulsivity, presenting with significant executive dysfunction, emotional regulation difficulties, and persistent functional impairments (Barkley et al., 1997). This executive dysfunction severely hinders an individual's ability to regulate responses to environmental stimuli, which in turn creates significant challenges in maintaining goal-directed behaviors and effective problem-solving. As noted by Barkley (1997), behavioral inhibition serves as the fundamental basis for other executive functions, and disruptions in this critical area directly weaken both self-control and focus.

Understanding adult ADHD also requires acknowledging the high prevalence of co-occurring psychiatric conditions. Research indicates that up to 80% of adults diagnosed with ADHD experience at least one comorbid psychiatric disorder during their lifetime (Katzman et al., 2017). The most frequent overlapping conditions include mood disorders, anxiety disorders, personality disorders, and substance use disorders. Identifying these complex clinical presentations is vital, as overlapping symptoms can significantly complicate the accurate recognition, diagnosis, and overall management of ADHD in adults.

To address these multifaceted challenges, Cognitive Behavioral Therapy (CBT) has emerged as a highly effective complementary approach to pharmacotherapy in adult ADHD treatment. While medications primarily focus on reducing symptoms, CBT specifically targets functional impairments, helping patients develop practical and effective coping strategies for their daily lives. Research by Safren et al. (2005) indicates that CBT not only provides noticeable improvements in core ADHD symptoms such as inattention, impulsivity, and hyperactivity, but also yields positive effects on accompanying psychological issues like depression, anxiety, and anger.

A crucial first step in adult ADHD treatment is psychoeducation, which aims to increase the individual's awareness of the disorder and establish environmental organization strategies to support areas where executive functions are vulnerable (Safren et al., 2005). Essential components of this phase include structuring workspaces, minimizing environmental distractors, and implementing task lists and calendar systems. Providing accurate information about the neurobiological roots of ADHD is transformative; it allows individuals to reframe their struggles as a neurodevelopmental difference rather than a personal failure. This critical shift in

perspective can substantially boost motivation and overall self-efficacy. Ultimately, CBT delivers a holistic treatment strategy that goes beyond mere symptom control, aiming instead for lasting improvements in cognitive awareness, self-efficacy, and functional living.

References

1. Barkley RA (1997) ADHD and the Nature of Self-Control. New York, Guilford Press, s. 45-68.
2. Katzman, M. A., Bilkey, T. S., Chokka, P. R., Fallu, A., & Klassen, L. J. (2017). Adult ADHD and comorbid disorders: clinical implications of a dimensional approach. BMC Psychiatry, 17(1), 302.
3. Safren SA, Otto MW, Sprich S, Winett CL, Wilens TE, Biederman J (2005) Cognitive-behavioral therapy for ADHD in medication-treated adults with continued symptoms. Behav Res Ther 43: 831-42.

Biopsychosocial Approach to Suspicious Female Deaths and the Responsibilities of Mental Health Professionals

Suzan Saner

Keywords: biopsychosocial, dehumanization, femicide, suspicious death**,** violence against women

In some cases of femicide, attempts are made to cover up the truth by recording the death as “suspicious,” portraying the incident as suicide or accident, or disposing of the body. In some suspicious death cases, it is seen that the violence against the woman was known before the death, but legal and psychosocial support mechanisms were insufficient.
According to the World Health Organization’s basic clinical care guidelines on the health consequences of violence against women (VAW), VAW is not an individual problem; it is both a cause and a consequence of gender inequality. Suspicious deaths of women are still made possible by this systematic and structural violence.
Although most professionals are aware that treating symptoms is an incomplete and inadequate solution to the mental health problem, they continue to do exactly that. Reasons for reluctance to directly address social determinants in the field of mental health include the perception that social determinants are outside their control, the inability to know how to address them within short examination periods, and fundamentally, the belief that this is not a clinician’s job.
The concept of dehumanization can be a useful approach to considering many forms of interpersonal and intergroup conflict. People who are seen as inferior to humans are subjected to violence, deprivation, exclusion, and dispossession; this suffering is routinely ignored or downplayed. While dehumanization is often understood as an extreme phenomenon limited to wars, genocides, and conquests, it exists on a spectrum. We can dehumanize not only those we hate but also those we are indifferent to in daily life.
People who believe they have been dehumanized by others often react negatively, hostilely. Or they may “dehumanize themselves” through internalization and have lower self-esteem and less functional coping mechanisms. Professionals may also dehumanize patients as a way of protecting themselves from emotional exhaustion and distress.
At the individual level, uncovering the woman’s history, including her perspectives on what caused the symptoms, is a fundamental first step. The importance of viewing the woman not as a “victim to be rescued” but as a subject to liberation will be discussed, along with what a busy professional can do in this regard. Teamwork can involve maintaining up-to-date lists of

organizations addressing social determinants such as employment, housing, shelter, and legal support, as well as women's advocacy groups; developing close contacts with key individuals within these organizations; and guiding the woman to establish new connections with support resources.

This presentation will argue that a biopsychosocial approach can move mental health care from a reductionist process to a more holistic and engaging one. Addressing social determinants during clinical interviews can be an empowering experience for patients, allowing them to feel that their real-world concerns are being heard and that they are actively participating in their own healing journey. It will help integrate the clinic with the community in a mutually empowering dynamic that liberates women from stigma and makes life more meaningful for them.

Designing feasible and sustainable mechanisms for preventing VAW through a multi-actor approach that coordinates the experience of feminist organizations, the capacity of the state, and the expertise of civil society and professional organizations will prevent future shortcomings.

References

1. WHO (2019) Caring for women subjected to violence: A WHO curriculum for training health-care providers.
2. Patel V (2025) What can practitioners do about social determinants of mental health? World Psychiatry, 24(3), 294–295.
3. Haslam N (2024) Dehumanization and Mental Health. World Psychiatry 23(2), 173-174

Invisible Chains at Individual and Societal Levels: Early and Forced Marriages

K. Lezgin Cihandemir
Bakırköy Mental and Neurological Diseases Hospital, Department of Psychiatry

Early and forced marriages (EFM) remain a significant global public health and human rights concern. Defined as marriages in which at least one party is under the age of 18 or where consent is not freely given, EFM disproportionately affect girls and young women. These practices not only impact individuals but also contribute structurally to the persistence of gender inequality.

One of the most prominent consequences of EFM is the interruption of girls' education. Leaving formal education reduces literacy and vocational opportunities and limits long-term socioeconomic mobility. As education is a key determinant of autonomy and health, this disruption reinforces the intergenerational transmission of poverty and inequality.

EFM also serve as a mechanism for reproducing traditional gender roles. Young women are often expected to assume domestic and caregiving responsibilities at an early age. This premature role assignment restricts identity formation and self-realization, which are developmentally critical during adolescence. Limitations in autonomy and decision-making power further normalize unequal power dynamics.

From a psychosocial perspective, EFM significantly alter developmental trajectories. Adolescence, defined by the World Health Organization (WHO) as the period between 10 and 19 years, is crucial for emotional, cognitive, and social development. Early marriage disrupts this period and increases vulnerability to mental health problems such as depression, anxiety, and trauma-related disorders.

In conclusion, EFM should be understood as structural phenomena that perpetuate gender inequality, restrict educational opportunities, and hinder self-realization. Addressing these issues requires multidisciplinary approaches, including legal regulations, educational policies, and community-based interventions that promote gender equality.

References

1. World Health Organization (2018) Adolescent health. Geneva: WHO.
   United Nations Children's Fund (UNICEF) (2021) Child marriage: Latest trends and future prospects. New York: UNICEF.
2. United Nations Population Fund (UNFPA) (2020) Child marriage and the rights of girls. New York: UNFPA.

Beyond CBT: From Schema Therapy to Third-Wave Approaches—Core Beliefs, Schemas, Emotion Regulation, and Values

Sevim Hacıarifoğlu Tolunay

In this section, the clinical needs that emerge during the middle and later stages of cognitive behavioral therapy (CBT), and the ways in which therapeutic deepening can be systematically structured in response to these needs, will be examined. Although symptom-focused interventions in the early stages may lead to a certain degree of improvement, in some cases this improvement remains limited or progress stagnates. At this point, the central clinical question is not “Which therapeutic approach should we switch to?” but rather, “At which level is the therapeutic impasse occurring in this client, and what is the most appropriate intervention at this stage?”

Therapeutic impasses encountered in the middle phase are often associated with recurring cognitive patterns, the persistence of avoidance behaviors, and the insufficient processing of emotional experiences. Such patterns may indicate that interventions remain confined to the level of automatic thoughts or that relevant contextual factors are not being adequately addressed. Accordingly, the therapeutic focus should shift toward deeper cognitive structures, such as core beliefs and schemas. Core beliefs related to inadequacy, unlovability, and worthlessness may contribute to the maintenance of symptoms by shaping the client’s emotion regulation processes, interpersonal functioning, and coping strategies.

The process of therapeutic deepening extends beyond the expansion of cognitive restructuring and encompasses emotional and experiential interventions. Within this framework, enhancing emotional awareness, strengthening emotion regulation capacities, addressing interpersonal patterns, and facilitating emotional processing through the therapeutic relationship become central components of treatment. A critical element in this process is the ongoing refinement of the case conceptualization. A comprehensive understanding of the relationships among the client’s symptoms, cognitive structures, emotional responses, and interpersonal patterns provides a framework for determining both the appropriate level of intervention and the selection of therapeutic techniques.

From this perspective, an integrative approach does not imply a mere combination of different therapeutic schools; rather, it involves the flexible and theoretically coherent application of interventions that are guided by the client’s needs and aligned with the case conceptualization. When classical CBT techniques, schema-focused interventions, and third-wave approaches are integrated at appropriate stages and levels, they facilitate not only symptom reduction but also more durable and generalizable therapeutic change.

References

1. Beck, J. S. (2020). Cognitive Behavior Therapy: Basics and Beyond (3rd ed.). Guilford Press.
2. Ögel, K. (2015). Farkındalık ve Kabullenme Temelli Terapiler. Boylam.
3. Young, J. E., Rafaeli, E., & Bernstein, D. P. (2018). Şema Terapi: Ayırıcı Özellikler. Psikonet.

Social Media And Clinical Reality
The Tendency For Self-Diagnosis And Its Impact On The Clinical Process

Habib Berhan AKYILDIZ
Gülhane Training and Research Hospital

In the digital age, social media platforms have facilitated access to mental health information and play an important role in the recognition and interpretation of psychiatric symptoms, particularly among young adults. However, this transformation has also reinforced individuals tendency to attribute psychiatric diagnoses to themselves without professional evaluation.
A key problem underlying social media driven self diagnosis is the decontextualized presentation of diagnostic categories. Brief, attention grabbing and algorithmically amplified content may encourage the interpretation of normal variations, developmental features or transient stress related symptoms within a pathological framework. Furthermore, core clinical parameters such as symptom severity, duration, functional impact and the need for differential diagnosis are often overlooked in these narratives.
Self diagnosis can be conceptualized as the process by which individuals match their experiences with symptoms encountered in online content and attribute them to a specific disorder without formal clinical evaluation. This tendency may overlap with cyberchondria, defined as a pattern in which health related internet use, initially driven by reassurance seeking, evolves into a repetitive and functionally impairing cycle. A systematic review highlights its strong association with health anxiety and increased healthcare utilization (Schenkel et al., 2021).
Equating transdiagnostic complaints with a single disorder may increase the risk of diagnostic delay and misdiagnosis, a pattern common in social media content. Nevertheless, self diagnosis should not be regarded as entirely detrimental. In some cases, online information may facilitate recognition of previously unarticulated symptoms, reduce stigma related concerns and promote help seeking behavior.
From a clinical perspective, self diagnosis may influence interview dynamics and the therapeutic alliance. When patients present with a predefined diagnostic expectation, clinical assessment may be perceived as confirmation, potentially constraining evaluation and narrowing differential diagnosis. This shift may lead to selective anamnesis and tension in the patient physician relationship. Supporting this, a pilot study reported that all young patients had been exposed to online mental health content and many endorsed diagnoses not established by clinicians, with social media contributing to these beliefs (Armstrong et al., 2025).

An appropriate clinical approach involves exploring patients online sourced information without judgment while emphasizing that diagnosis is based on structured clinical evaluation rather than symptom similarity alone. Although social media may facilitate help seeking, it can also reinforce diagnostic misconceptions. Increasing the visibility of healthcare professionals and promoting evidence based content that directs individuals toward clinical assessment may help reduce the gap between digital narratives and clinical reality.

References

1. Schenkel, S. K., Jungmann, S. M., Gropalis, M., & Witthöft, M. (2021). Conceptualizations of cyberchondria and relations to the anxiety spectrum: Systematic review and meta-analysis. Journal of Medical Internet Research, 23(11), e27835.
2. Armstrong, S., Osuch, E., Wammes, M., Chevalier, O., Gropalis, M., Jungmann, S. M., & Witthöft, M. (2025). Self-diagnosis in the age of social media: A pilot study of youth entering mental health treatment for mood and anxiety disorders. Acta Psychologica, 256(1), 105015.

Report Preparation in Psychiatry
Firearm License, Smoothbore Shotgun License, Private Security, Law Enforcement and Legal Capacity Applications

Hatice Öztürk
Adana City Training and Research Hospital, Psychiatry Department

In psychiatry, reporting is an area that goes beyond clinical assessment, intersecting with legal, ethical, and social responsibility. This course will comprehensively address the psychiatrist's decision-making processes through firearm licenses, shotgun licenses, private security guard positions, law enforcement personnel assessments, and legal capacity assessments. While each of these areas is based on different regulations, they aim to answer a common question: "Does this individual, in their current mental state, pose a risk to themselves and to society?"

In firearm license assessments (firearms and shotguns), the fundamental approach is to conduct a risk analysis rather than to make a diagnosis (Turkish Psychiatric Association,2011) The presence of an active psychiatric illness, past behavioral patterns, impulse control, substance use, and a history of suicide are determining factors in this assessment. In private security and law enforcement personnel, the assessment is not limited to individual risk; the social risk dimension comes to the fore due to active duty, the authority to use force, and access to weapons. On the other hand, legal capacity assessment is concerned with the capacity to discern under civil law. The key here is not the diagnosis itself, but the individual's capacity to understand, reason, evaluate consequences, and make decisions at a particular legal juncture.

The primary aim of this course is to develop the psychiatrist's ability to manage gray areas, moving beyond binary judgments such as "appropriate/inappropriate." Regulations do not address cases in the gray area. Through case-based discussions, critical concepts such as impulse control, functioning under stress, adherence to treatment, and the predictive value of past behavior will be addressed. Furthermore, the boundaries of the psychiatrist's role—the difference between medical opinion and administrative decision—will be emphasized.

Reference

1. Turkish Psychiatric Association. Guidelines for psychiatric examinations of individuals applying for firearm licenses. Ankara: Turkish Psychiatric Association; 2011.

Neuroimaging and Biomarkers in Predicting Diagnostic Stability and Disease Course in First-Episode Psychosis

Kübra Dikici Saraçoğlu
Başakşehir Çam and Sakura City Hospital

The critical importance of early diagnosis and treatment in psychotic disorders for prognosis has led the concept of first-episode psychosis (FEP) to occupy a central place in clinical practice. In FEP, which shows marked heterogeneity in clinical presentation and course, interest in neuroimaging and peripheral inflammatory markers is increasing in order to predict disease trajectory and diagnostic stability. Magnetic resonance imaging (MRI) studies aim to reveal the relationship between neuromorphological changes and clinical outcomes, and voxel-based morphometry (VBM) is frequently used to assess structural brain changes.
The inflammation hypothesis has gained prominence in explaining the biological mechanisms underlying these changes. Similar cytokine profiles in schizophrenia and psychotic bipolar disorder suggest that inflammatory processes may play an active role in pathophysiology. Inflammatory mediators may influence neural development, synaptic plasticity, and glial activity, contributing to structural alterations. Elevated C-reactive protein (CRP) levels during acute psychosis have been associated with changes in frontal, insular, and temporal cortical regions.
Studies integrating neuroimaging and peripheral inflammatory markers suggest that the course of FEP may be predicted early in the illness. Based on this framework, the present study aimed to investigate the relationship between peripheral inflammatory markers and brain morphology, and their predictive value for diagnostic stability and disease course.
Data from 51 patients with FEP hospitalized between September 2020 and October 2024 at Başakşehir Çam and Sakura City Hospital were analyzed. Peripheral inflammatory markers were calculated from blood samples, and gray matter volumes were assessed using VBM based on T1-weighted MRI data. Group comparisons and mediation analyses were performed. During follow-up, schizophrenia spectrum, bipolar disorder, and major depressive disorder diagnoses showed high diagnostic stability. While no significant group differences were found in scale scores or inflammatory ratios, monocyte-weighted indices showed stronger associations with clinical variables.
VBM analyses showed higher gray matter volume in several frontal and occipito-temporal regions in the major depressive disorder group compared to other groups. Monocyte levels were positively associated with the right primary sensory cortex and posterior cerebellum, and negatively associated with the left precuneus. Gray matter volume mediated the relationship

between monocyte-to-lymphocyte ratio (MLR) and negative symptoms.
These findings highlight the importance of shared biological mechanisms across psychosis spectrum disorders and suggest that the interaction between peripheral inflammation and brain
morphology may contribute to symptom profile and functioning.

References

1. Dwyer DB, Chand GB, Pigoni A, Khuntia A, Wen J, Antoniades M, et al. Psychosis brain subtypes validated in first-episode cohorts and related to illness remission: results from the PHENOM consortium. Mol Psychiatry. May 2023;28(5):2008-17.
2. Lesh TA, Careaga M, Rose DR, McAllister AK, Van de Water J, Carter CS, et al. Cytokine alterations in first-episode schizophrenia and bipolar disorder: relationships to brain structure and symptoms. J Neuroinflammation. Dec 2018;15(1):165.
3. Guloksuz S, van Os J. The slow death of the concept of schizophrenia and the painful birth of the psychosis spectrum. Psychol Med. Jan 2018;48(2):229-44.

Child Marriages

Şeyma DURAN
Reyhanlı State Hospital

Child marriage refers to the formal or informal union of individuals under the age of 18, and according to UNICEF and national legislation, 18 years is recognized as the threshold for childhood. This situation leads individuals to assume marital responsibilities without achieving physical, mental, and psychological maturity, thereby negatively affecting their developmental processes. As a significant global public health and human rights issue, it is reported that approximately 21% of women worldwide are married before the age of 18, and millions of girls are affected by this situation every year (UNICEF, 2023).

Similarly in Türkiye, child marriage has been found to have negative effects on education, employment, and health outcomes; women who marry at an early age have lower labor force participation rates and are predominantly employed in insecure and informal jobs (Hacettepe University Institute of Population Studies, 2019).

The emergence of child marriage is influenced by socioeconomic disadvantages, low educational attainment, traditional practices, social pressures, and gender inequality. In particular, patriarchal social structures contribute to the exclusion of girls from decision-making processes and the normalization of early marriage. In this context, social norms and cultural practices play a significant role in the persistence of child marriage (UNFPA, 2020).

The consequences of child marriage are multidimensional. Adolescent pregnancies pose serious risks to maternal and neonatal health, while mental health problems such as depression, anxiety, and post-traumatic stress disorder are more commonly observed. In addition, discontinuation of education, economic dependency, reduced participation in the workforce, and increased risks of violence and abuse are important social consequences. These conditions significantly reduce individuals' quality of life in the long term (UNFPA, 2020).

In this context, within the panel discussion, the challenges faced by mental health professionals working with individuals who have experienced child marriage, as well as key considerations in clinical practice, will be addressed through case examples. In particular, trauma-informed approaches, ethical considerations, and multidisciplinary intervention processes are emphasized as important aspects of this issue.

References

1. UNICEF. (2023). Child marriage. https://www.unicef.org/protection/child-marriage
2. Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü. (2019). 2018 Türkiye Nüfus ve Sağlık Araştırması (TNSA). Ankara.
3. UNFPA (2020). Child marriage. https://www.unfpa.org/child-marriage

Reflections from the Psychiatric Clinic: Working with Norms of Well-Being

Dr. Bestenur Guvendi Melenkis
Istanbul Erenkoy Psychiatric And Neurological Diseases Training And Research Hospital

In psychiatric assessment, well-being is most commonly defined through the reduction of symptoms, improved functioning, and the patient's ability to re-engage with daily life. Yet this definition leaves a critical question unanswered: when we speak of adaptation, do we mean a reduction in the person's suffering or a return to the existing order of their life? A shift in clinical language is increasingly apparent. Patients now present not only with insomnia, low mood, or anxiety, but with expressions such as "I can't keep up with anything," "I don't like what I see in the mirror," "I just can't pull myself together." This language may reflect not only individual distress, but the experience of falling short of particular expectations. The symptom is sometimes articulated not as internal suffering, but as an inability to meet prevailing norms. For women, the ideal of "being well" is often shaped within a multilayered and contradictory set of expectations: to appear physically groomed and youthful, to remain emotionally balanced and composed, to be productive and capable of managing everything, and to serve as a good mother, good partner, and primary caregiver. These norms are not only externally imposed — over time they are internalized, becoming part of how a person relates to herself. Once internalized, any shortfall in meeting them is experienced not as exhaustion or structural impossibility, but as personal failure.

The literature gives this observation empirical weight. Bassoli (2025), drawing on data from over 40,000 individuals across Europe, shows that stronger traditional gender norms in the family domain significantly increase depression in women, with no equivalent effect in men suggesting that norms do not merely reflect culture, but actively shape mental health outcomes. Sarda et al. (2025), in a systematic review, find that appearance-focused social media use intensifies self-objectification and body image distress. Aviv et al. (2024), in a study of 322 mothers, demonstrate that the cognitive dimension of household labor the planning, anticipating, and monitoring that runs invisibly in the background is distributed even more unequally than physical domestic work, and is directly associated with depression, stress, burnout, and relationship difficulty.

Drawing on Gill's concept of self-surveillance, this presentation argues that these pressures converge at the intersection of psychopathology and internalized expectation most visibly in presentations involving health anxiety, body image disturbance, and restrictive or controlling patterns around eating. In each case, the clinical question is not only whether a symptom is

present, but whether what appears as pathology might simultaneously reflect the weight of an obligation to remain in control, to appear well, and to meet a standard that is never fixed.

The postpartum period offers a particularly illuminating context. Postpartum distress does not arrive in isolation it is frequently entangled with the ideal of intensive mothering: the expectation of immediate bonding, constant availability, and the seamless embodiment of the "good mother" role. Suffering in this period is thus experienced not only as depressive or anxious symptoms, but as guilt, perceived inadequacy, and a sense of falling short of a social norm.

A different clinical approach is both possible and necessary. Taking the symptom seriously while also attending to its context; questioning excessive functioning rather than equating it with recovery; making invisible cognitive and caregiving labor visible in the assessment; and interpreting the patient's language of inadequacy not as evidence of individual pathology, but as an expression shaped within a specific normative field. The question is not only which diagnosis but which burden, which expectation, and under which conditions.

References

1. Aviv E, Waizman Y, Kim E ve ark. (2024) Cognitive household labor: gender disparities and consequences for maternal mental health and wellbeing. Arch Womens Ment Health 28: 5–14.
2. Bassoli E (2025) How gender norms shape the health of women and men? Soc Sci Med 383: 118479.
3. Öztunç M, Akıncı Çötok N, Işıkgöz ME ve ark. (2025) Digital culture and aesthetic orientation: associations with body perception and beauty perception on social media. BMC Psychol 13: 1178.

Sexual Identity Diversity in the Outpatient Clinic: Evaluation and Clinical Management with Cases

Koray Başar (Department of Psychiatry, Hacettepe University Faculty of Medicine)
Şahika Yüksel (Independent Psychiatrist / Private Practice)
Tayfun Özbek (Department of Psychiatry, Ankara Bilkent City Hospital)
Sena Akpolat (Department of Psychiatry, Ankara Bilkent City Hospital)
Pelin Göksel (Department of Psychiatry, Ondokuz Mayıs University Faculty of Medicine)
Sinan Hiçdönmez (Department of Psychiatry, Marmara University Faculty of Medicine)

Sexual identity encompasses the development of sex characteristics, gender identity and expression and sexual orientation, and may vary greatly from one person to another. In societies which expect gender to align with assigned gender, and sexual orientation to be towards the opposite sex, the components of this diversity may make it difficult for one to question, discover and express. This process is not only a matter of personal identity development, but instead is a multi-layer question deeply connected to relationships with family, education, work, and access to healthcare. Individuals, in this context, may find it difficult to access family support and social support, and may be ostracized due to overt or covert stigmatizing attitudes.

While the stigmatizaton may make participation in education and work difficult, it may also adversely affect medical and mental health. Constant stress, contraction of safe space, fear of being identified, and internalized negative attitudes towards oneself may increase anxiety, depressive symptoms, trauma-related complaints and risk-taking behavior. Sexual minority groups may seek referrals to mental health professionals at any age, and reasons for referrals are often not limited to questions about identity but may rather include issues related to relationships, family, loss of daily functioning, and any accompanying medical or mental comorbidities.

For such issues to be adequately addressed, psychiatrists need to be familiar with concepts concerning sexual identity and any possible health risks. It is possible through clinical and non-clinical support to increase psychological resilience, achieve and sustain medical, mental and social well-being in such individuals and their families. Safe, nonjudgmental and inclusive clinical environments, the use of correct terminology, strict adherence to privacy, appropriate advice and multidisciplinary collaboration are cornerstones in good care.

However, the necessary emphasis on quality care for such individuals is still lacking in medical education.

This course will offer a wide-scoped theoretical basis illustrated in five cases representative of the diversity of sexual identity seen in psychiatric outpatient practice, and offer participants a framework for interviewing, proper evaluation, intervention and support.

Borderline Representations in Painting

İmge İlke Özel
İstanbul Silivri State Hospital

This presentation examines borderline themes in painting through selected works by Frida Kahlo, Edvard Munch, and Mark Rothko. Painting, as a visual form based on leaving a trace or creating an image, allows the expression of complex emotional states. In this sense, it can be understood as a reflection of all aspects of being human. Like all forms of art, it reflects a wide range of inner life and therefore provides a strong space where borderline phenomena can be expressed and symbolized.

Frida Kahlo's The Two Fridas (1939) is a powerful visual example of splitting, one of the main defense mechanisms in borderline personality organization. The two figures sitting side by side represent a divided sense of self. This division reflects the coexistence of "loved" and "rejected" parts of the self that cannot be integrated. The exposed hearts, the cut blood vessel, and the figures holding hands emphasize emotional vulnerability, abandonment, and attempts at self-soothing.

In The Scream (1893), Munch transforms an intense inner experience into a universal image of anxiety and existential fear. The central figure, which lacks a clear identity and seems merged with its surroundings, suggests experiences such as depersonalization and derealization. The uncertainty about whether the figure is screaming or reacting to a scream points to a collapse of internal and external boundaries. The distorted landscape reflects unregulated emotions and makes the intensity and instability of borderline experience visible.

Mark Rothko's abstract works move away from figures and instead use color fields to create a direct emotional experience. His later paintings, especially those in darker tones, evoke feelings of emptiness, loneliness, and being overwhelmed. The unclear boundaries between color blocks can be seen as a visual metaphor for the blurred boundaries between self and others in borderline organization. Rather than representing emptiness, Rothko's paintings embody the experience of emptiness itself.

Beyond these examples, similar themes can be found throughout art history. Splitting in Klimt's Death and Life, fragmented body images in Francis Bacon's works, weakness of sense of self in Vincent van Gogh's self-portraits, and loneliness in Edward Hopper's paintings can all be interpreted within a borderline framework.

In conclusion, the themes discussed under borderline representations are not limited to pathology. They are part of universal human experience. Like all aspects of the human psyche, they naturally become material for art and find expression within it.

References

1. Yeomans, Frank E.; Clarkin, John F.; Kernberg, Otto F. Borderline Kişilik Bozukluğu İçin Aktarım Odaklı Psikoterapi: Klinik Bir Rehber. İstanbul: Psikoterapi Enstitüsü, 2017.
2. Ogden, T. H. (2018). Şu psikanaliz sanatı: Görülmemiş rüyaları görmek, kesintiye uğramış çığlıkları duymak. İstanbul: İstanbul Bilgi Üniversitesi Yayınları.
3. Kernberg, O. F. (2016). Sınır durumlar ve patolojik narsisizm (Çev. B. Aydın & A. Tükel). İstanbul: Metis Yayınları.

Working with Anger in Schema Therapy: A Clinical Roadmap for the Therapist

Leyla Abdullayeva

Anger in the therapy room is often experienced as disruptive, intimidating, or even personal. However, within Schema Therapy, anger is not viewed as a problem to eliminate but as a meaningful signal that points to unmet emotional needs, activated schemas, and protective coping modes. For the therapist, the task is not to suppress anger but to understand, regulate, and work through it with precision and care.

The first step in the clinical roadmap is maintaining the Healthy Adult mode. When faced with anger—whether expressed as rage, sarcasm, passive resistance, or self-criticism—the therapist must resist the pull into their own maladaptive modes, such as avoidance, appeasement, or counterattack. Grounded presence, emotional regulation, and reflective awareness allow the therapist to remain steady and attuned.

Next, the therapist works to identify and differentiate anger modes. Anger may arise from an Angry Child (linked to unmet needs, frustration, or abandonment), a Bully/Attack mode (overcompensation through control or dominance), or a Detached Protector (masking anger through disengagement). Accurate mode identification guides intervention and prevents misattunement.

Once the mode is identified, the therapist explores the underlying unmet needs. Anger often masks deeper vulnerabilities such as shame, fear, rejection, or helplessness. Through empathic attunement, the therapist validates the emotional experience while gently linking it to early maladaptive schemas and past relational patterns. This process transforms anger from a reactive discharge into a meaningful narrative.

A crucial component of the roadmap is empathic confrontation. The therapist simultaneously validates the patient's emotional pain while setting limits on maladaptive expressions of anger. For example, aggressive or demeaning behavior is not accepted, but the underlying hurt is acknowledged and explored. This dual stance strengthens the therapeutic alliance while promoting responsibility.

Experiential techniques play a central role in working with anger. Imagery rescripting allows patients to revisit early experiences where anger was unsafe or suppressed, providing corrective emotional experiences. Mode dialogues help externalize conflicting parts, enabling patients to observe and regulate their anger more consciously. Chair work can be particularly effective in differentiating the Angry Child from punitive or demanding internal voices.

Another important step is personalizing the anger mode. Giving the anger a name (e.g., "The Volcano," "The Controller," "The Hurt Fighter") enhances awareness and helps patients track

triggers, bodily sensations, and escalation patterns. This also facilitates self-reflection and regulation outside the therapy room.

The therapist must also remain mindful of countertransference. Patient anger can activate the therapist's own schemas, leading to withdrawal, defensiveness, or overcompensation. Ongoing supervision, self-reflection, and personal therapy are essential to maintain therapeutic effectiveness and authenticity.

Finally, anger work in Schema Therapy aims to transform rather than eliminate. As patients learn to access their Healthy Adult mode, they become better able to express anger assertively, recognize their needs, and seek fulfillment in adaptive ways. Anger, once chaotic and destructive, becomes integrated as a source of information, energy, and self-protection.

In this way, the therapist's clinical roadmap is not about controlling anger, but about decoding it—listening carefully to what it reveals, and guiding the patient toward healthier ways of feeling, relating, and living.

References

1. Schema therapy for borderline personality disorder (Arnoud Arntz and Hannıe Van Genderen)
2. Schema therapy in practice (Arnoud Arntz, Gitta Jacob)

From Soviet Psychiatry to Modern Psychiatry in Azerbaijan: Advantages and Barriers

Leyla Abdullayeva

The transition from Soviet psychiatry to modern psychiatric practice in Azerbaijan reflects a broader transformation from a rigid, institutional, and biologically dominated system toward a more holistic, patient-centered model. Soviet psychiatry was largely characterized by hospital-based care, a strong emphasis on diagnosis and pharmacological treatment, and limited attention to psychotherapy, patient autonomy, and human rights. In contrast, modern psychiatry emphasizes biopsychosocial assessment, evidence-based interventions, and community-oriented mental health services.

One of the key advantages of this transition has been the integration of international standards into psychiatric care. Azerbaijan has increasingly aligned its mental health services with frameworks promoted by organizations such as the World Health Organization, focusing on deinstitutionalization, community-based care, and the protection of patient rights. This has led to the gradual development of multidisciplinary teams, including psychologists, social workers, and rehabilitation specialists. Additionally, exposure to global training programs has improved the competencies of younger professionals, introducing approaches such as cognitive-behavioral therapy and schema therapy.

Another advantage is the growing awareness of mental health in society. Public discourse, digital platforms, and professional advocacy have contributed to reducing stigma, although this remains a work in progress. The shift toward patient-centered care has also encouraged greater therapeutic alliance and individualized treatment planning.

However, significant barriers persist. The legacy of institutionalization continues to influence clinical practice, with limited outpatient and community-based resources in some regions. There is also a shortage of trained mental health professionals, particularly in psychotherapy modalities. Financial constraints and uneven resource distribution further complicate access to quality care. Moreover, cultural stigma and misconceptions about mental illness still discourage help-seeking behaviors.

Another challenge is the partial integration of modern approaches. While reforms are underway, inconsistencies remain in implementation, supervision, and quality assurance. Bridging the gap between traditional practices and contemporary models requires sustained investment in education, policy reform, and interdisciplinary collaboration.

In conclusion, Azerbaijan’s transition to modern psychiatry presents meaningful progress alongside ongoing challenges. Strengthening community services, expanding professional

training, and addressing stigma will be essential for building a more effective and humane mental health system.

References

1. World Health Organization (2013). Mental Health Action Plan 2013–2020.
2. World Psychiatric Association (2017). Position Statements on Community Mental Health.
3. Ministry of Health of the Republic of Azerbaijan. National Mental Health Strategy and Reform Initiatives.

Diagnostic Heterogeneity and Diagnostic Stability in First-Episode Psychosis

İmren Kurt Sabitay
Kocaeli City Hospital, Department of Psychiatry, Kocaeli, Turkiye; Koç University, Neuroscience PhD program, Istanbul, Turkiye

First-episode psychosis (FEP) refers to the initial manifestation of psychotic symptoms in individuals who have not yet achieved full remission. Although widely used in clinical practice, FEP does not represent a single diagnostic entity; rather, it constitutes a clinical framework encompassing a range of disorders, including schizophrenia spectrum disorders, bipolar disorder, and major depressive disorder with psychotic features. This inherent diagnostic heterogeneity poses significant challenges for diagnostic validity and for predicting the course of illness.

The early phase of psychosis is considered a critical period, as timely recognition and intervention have been associated with improved outcomes. However, longitudinal studies indicate that outcomes following FEP are highly variable. While some individuals achieve full remission, a substantial proportion experience persistent symptoms, relapses, or chronic functional impairment, underscoring the heterogeneity not only in diagnosis but also in clinical trajectories. Furthermore, diagnostic stability across follow-up studies is inconsistent. Meta-analytic evidence demonstrates that schizophrenia and affective psychoses show relatively high diagnostic stability, whereas other categories, such as schizophreniform disorder or psychosis not otherwise specified, frequently shift over time. These findings suggest that diagnostic uncertainty is an inherent feature of early psychosis rather than solely a reflection of clinical error.

Recent advances in data-driven approaches further challenge traditional categorical classifications. Machine learning studies have identified distinct longitudinal subtypes of FEP based on symptom trajectories, including groups characterized by low symptom burden, persistent negative symptoms, and severe clinical course. Importantly, these subtypes are not fully explained by conventional diagnostic categories. In parallel, neuroimaging studies have revealed biologically distinct subgroups with differential patterns of brain morphology associated with divergent clinical outcomes, supporting the presence of early neurobiological heterogeneity. These findings raise critical questions regarding the adequacy of categorical diagnostic systems. Accumulating evidence suggests that psychotic phenomena may be better conceptualized along a continuum, ranging from subclinical experiences to severe and persistent disorders. Dimensional and transdiagnostic approaches, such as spectrum models and staging frameworks, have been proposed to better capture this complexity, although their

clinical implementation remains limited. In this context, the identification of reliable biomarkers is essential. Peripheral inflammatory markers, neuroimaging findings, and genetic factors may contribute to refining diagnostic precision and enabling individualized treatment strategies. A more comprehensive understanding of the biological and clinical heterogeneity of FEP may ultimately facilitate the development of personalized interventions and improve prognostic accuracy.

References

1. Fusar-Poli P, Cappucciati M, Rutigliano G, Heslin M, Stahl D, Brittenden Z, Caverzasi E, McGuire P, Carpenter WT. Diagnostic Stability of ICD/DSM First Episode Psychosis Diagnoses: Meta-analysis. Schizophr Bull. 2016 Nov;42(6):1395-1406. doi: 10.1093/schbul/sbw020. Epub 2016 Mar 15. PMID: 26980142; PMCID: PMC5049518.
2. Griffiths SL, Lalousis PA, Wood SJ, Upthegrove R. Heterogeneity in treatment outcomes and incomplete recovery in first episode psychosis: does one size fit all? Transl Psychiatry. 2022 Nov 17;12(1):485. doi: 10.1038/s41398-022-02256-7. PMID: 36396628; PMCID: PMC9671914.
3. Dwyer, D.B., Chand, G.B., Pigoni, A. et al. Psychosis brain subtypes validated in first-episode cohorts and related to illness remission: results from the PHENOM consortium. Mol Psychiatry 28, 2008–2017 (2023). https://doi.org/10.1038/s41380-023-02069-0

The Role of Women in The Intergenerational Transmission of Trauma

Serap Erdoğan Taycan
Istanbul Okan University, Psychology Department

War has long been narrated through military and political lenses, yet its most lasting consequences are inscribed on women's bodies, minds, and communities. This presentation explores the intersections of gender, conflict, and intergenerational trauma, highlighting women not merely as victims but as carriers, translators, and potential healers of collective psychic wounds. Drawing on contemporary psychiatric, psychoanalytic, and sociocultural research, it addresses how the feminine experience of war becomes a primary medium through which trauma is transmitted—and transformed—across generations.

Biological studies reveal that maternal exposure to terror, displacement, or sexual violence during conflicts alters neuroendocrine functioning and epigenetic expression. The work of Yehuda et al. (2014, Biological Psychiatry) demonstrates that heightened cortisol or glucocorticoid receptor methylation in traumatized mothers predicts stress dysregulation in their offspring, decades later. Thus, war's psychological footprint extends well beyond its historical moment, shaping children's affective regulation and vulnerability to anxiety or depression.

Psychodynamically, what cannot be mourned is sealed within psychic "crypts." In many post-war societies, women—tasked with preserving family and cultural continuity—become the principal custodians of such silent memories. Through unspoken narratives, gestures, and everyday rituals, they convey what Marianne Hirsch (1997) terms postmemory: a form of secondhand remembrance lived as if it were one's own. Intergenerationally, this produces patterns of hypervigilance, guilt, or identity diffusion frequently observed in descendants of war survivors.

Culturally, women's practices of cooking, storytelling, lamentation, and communal caregiving transform traumatic memory into collective meaning. Feminist and postcolonial theorists (e.g., Fanon, 1961) suggest that this transformation embodies a "feminine ethic" of survival: compassion and relationality emerging from devastation. Psychotherapeutically, narrative and group-based interventions that recognize women's dual role—as bearers and agents of reconstruction—facilitate both individual recovery and community resilience.

Ultimately, understanding women's roles in intergenerational trauma reframes psychiatry itself: healing is not confined to the intrapsychic sphere but unfolds through social bonds, storytelling, and rehumanization. In the ruins of war, women sustain life's continuity; their

memories constitute the living archive through which humanity remembers—and learns—how to survive its own violence.

Keywords: war trauma, women, intergenerational transmission, epigenetics, postmemory, collective resilience, psychosocial healing

References

1. Fanon, F. (1963). The wretched of the earth (C. Farrington, Trans.). Grove Press. (Original work published 1961)
2. Hirsch, M. (1997). Family frames: Photography, narrative, and postmemory. Harvard University Press.
3. Yehuda, R., Lehrner, A., Daskalakis, N. P., & Bierer, L. M. (2021). Intergenerational transmission of trauma effects: Putative role of epigenetic mechanisms. Translational Psychiatry, 11(1), 193.

Predictors of Good Response to Electroconvulsive Therapy: Clinical, Ictal, and Biological Dimensions

İbrahim Akbaş

Electroconvulsive therapy (ECT) remains the most effective acute treatment for severe mood disorders, yet response variability necessitates identification of reliable predictors. Evidence from contemporary and foundational studies converges on three interacting domains: clinical phenotype, ictal seizure characteristics, and biological markers.

Clinical predictors

Clinical variables remain the most robust and clinically actionable predictors of ECT response. Across studies, **psychotic depression**, **melancholic features**, and **catatonia** consistently predict superior outcomes (Fink, 2014; Sienaert, 2011). **Greater baseline severity** and **shorter episode duration** are also associated with faster and higher remission rates. Conversely, prolonged treatment resistance may attenuate response, although ECT remains effective even in refractory populations (Sackeim, 2017). Age has a modest positive effect, with **older patients often demonstrating better outcomes**, potentially reflecting distinct biological subtypes. Early clinical improvement during the ECT course further predicts eventual remission, emphasizing the value of dynamic assessment.

Ictal (seizure-related) predictors

Ictal parameters provide mechanistic and prognostic insight, although their predictive strength is moderate and context-dependent. Traditional emphasis on **seizure duration** alone is insufficient; instead, **seizure quality** is more informative. Key markers include:

- **Postictal suppression**: one of the most replicated predictors, reflecting global cortical inhibition and associated with better clinical outcomes (Francis-Taylor et al., 2020).
- **Ictal EEG organization and amplitude**: greater regularity and higher amplitude correlate with response.
- **Composite seizure quality indices**: integrating multiple EEG features improves predictive validity.

Emerging work highlights **ictal theta power** as a potential early biomarker linked to antidepressant response trajectories and cognitive outcomes (Miller et al., 2023). Importantly, ictal features are strongly influenced by **stimulus parameters (dose, electrode placement, pulse width)**, underscoring the interaction between technique and biology (Deng et al., 2024).

Biological predictors

Biological markers offer promising but currently less consistent predictive value. Neurobiological models suggest that both **electrical field distribution** and **seizure-induced neuroplasticity** contribute to therapeutic effects (Kritzer et al., 2023; Deng et al., 2024). Key

findings include:

- **Neuroimaging markers** (e.g., hippocampal volume, connectivity changes) associated with response, though not yet clinically decisive.
- **Electrophysiological biomarkers**, including baseline EEG features and ictal spectral power, show emerging utility.
- **Molecular and neurotrophic changes** (e.g., BDNF modulation) are implicated but lack predictive specificity.

Overall, biological predictors remain heterogeneous and are not yet ready for routine clinical stratification.

Conclusion

The best predictors of ECT response are still **clinical**, particularly psychotic features, severity, and illness subtype. **Ictal EEG markers**, especially postictal suppression and composite seizure quality indices, add meaningful but moderate predictive value. **Biological markers** are advancing toward precision psychiatry but currently lack consistency for clinical implementation. Future progress lies in **integrated, multimodal models** combining clinical phenotype, real-time ictal metrics, and neurobiological signatures to guide personalized ECT.

References

1. Pinna M, Manchia M, Oppo R, Scano F, Pillai G. Clinical and biological predictors of response to electroconvulsive therapy (ECT): a review. Neurosci Lett. 2018;669:32–42.
2. Deng ZD, Robins PL, Regenold W, Rohde P, Dannhauer M, Lisanby SH. How electroconvulsive therapy works in the treatment of depression: is it the seizure, the electricity, or both? Neuropsychopharmacology. 2024;49:150–162.
3. Sackeim HA. Modern electroconvulsive therapy: vastly improved yet greatly underused. JAMA Psychiatry. 2017;74(8):779–780.

Acute Suicide Risk in the Medical Department: Clinical Assessment and Management

Hale Yapıcı Eser
Koç University, School of Medicine, Department of Psychiatry, İstanbul, Türkiye
Koç University, Graduate School of Health Sciences, Neuroscience Program, İstanbul, Türkiye

Physical illness and hospital admission are recognized as significant stressors that can elevate suicide risk among patients in medical wards. While clinical environments are designed to ensure safety, the transition into a hospital and the period immediately following discharge represent high-risk windows for suicidal behavior. Patients in non-psychiatric settings often face unique challenges, such as the psychological burden of chronic disease, terminal diagnoses, pain or sudden loss of physical autonomy, which can lead to acute distress. Despite these risks, suicide prevention in medical units is frequently complicated by a focus on physical symptoms and a lack of standardized mental health screening protocols.

Current literature highlights that relying solely on depression screening tools is often insufficient for identifying individuals at risk for suicide. Many patients who experience suicidal ideation do not meet the full clinical criteria for depression, or they may prioritize reporting physical pain over emotional suffering. Consequently, a significant portion of at-risk individuals may be missed if clinicians use depression as the only proxy for suicide risk. To address this gap, recent studies advocate for the implementation of universal and direct screening tools that specifically ask about suicidal thoughts and behaviors. These tools are generally well-received by patients and can be integrated into routine nursing assessments without causing undue distress.

Effective management of acute suicide risk in the medical service also requires a multi-disciplinary approach. This involves not only the use of validated screening instruments but also the specialized training of clinical staff to recognize warning signs beyond verbal expressions, such as sudden behavioral changes or treatment refusal. When a risk is identified, immediate intervention strategies—including environmental safety modifications, increased observation, and psychiatric consultation—are essential. Lack of psychiatry inpatient wards that will provide sufficient medical care in addition to psychiatric care, lack of medical wards that may help for close and safe monitoring of suicide risk and also lack for social support systems complicates the follow up procedures of the patients. Furthermore, establishing clear protocols for post-discharge care and ensuring a seamless transition to mental health services are critical for long-term patient safety. Ultimately, moving toward a proactive culture of screening in all healthcare settings is vital to preventing inpatient suicide. This presentation will cover the different aspects for clinical assessment and management of suicide risk in the medical departments.

References

1. Wan Q, Ding X, Hu D, Han Y, Wang S, Liu Y, et al. A study of the epidemiology and risk factors for attempted suicide and suicide among non-psychiatric inpatients in 48 general hospitals in Hubei province, China, 2015-2017. Gen Hosp Psychiatry. 2020;63:21-29.
2. Inoue K, Kawanishi C, Otsuka K, Cho Y, Shiraishi M, Ishii T, et al. A large-scale survey of inpatient suicides: comparison between medical and psychiatric settings. Psychiatry Res. 2017;250:155-158.
3. Irigoyen-Otiñano M. The need to establish a suicide risk protocol in hospitalization units. Actas Esp Psiquiatr. 2023;51(1):44-45.
4. Fedorowicz SE, Dempsey RC, Ellis N, Phillips E, Gidlow C. How is suicide risk assessed in healthcare settings in the UK? A systematic scoping review. PLoS One. 2023;18(2):e0280789.
5. Mournet AM, Smith JT, Bridge JA, Boudreaux ED, Snyder DJ, Claassen CA, et al. Limitations of Screening for Depression as a Proxy for Suicide Risk in Adult Medical Inpatients. J Acad Consult Liaison Psychiatry. 2021;62(4):413-420.
6. Horowitz LM, Snyder D, Ludi E, Rosenstein DL, Kohn-Godbout J, Lee L, et al. Ask Suicide-Screening Questions to Everyone in Medical Settings: The asQ'em Quality Improvement Project. Psychosomatics. 2013;54(3):239-247.

One Topic in Ten Questions: Female Sexual Interest/Arousal Disorder: What, Why, and How in Clinical Practice?

Conceptual Framework and Prevalence of Female Sexual Interest/Arousal Disorder

Didem Sücüllüoğlu Dikici

Female Sexual Interest/Arousal Disorder (FSIAD), as defined in the DSM-5, is characterized by a marked reduction or absence of sexual interest, sexual thoughts and fantasies, initiation of sexual activity, responsiveness to a partner's initiation, and/or subjective or physiological arousal during sexual activity, persisting for at least six months. A key diagnostic requirement is that these symptoms cause clinically significant personal distress. In clinical practice, common presentations include avoidance of sexual activity, reduced responsiveness to a partner's physical contact or initiation, perceiving sexual activity as an obligation, and a lack of both mental and physical arousal during sexual encounters.

A major change introduced in DSM-5 is the integration of previously distinct diagnoses—Hypoactive Sexual Desire Disorder (HSDD) and Female Sexual Arousal Disorder (FSAD)—into a single diagnostic category. This shift reflects evidence that female sexual response is not strictly linear or driven solely by spontaneous desire. Instead, sexual desire in many women is responsive in nature, emerging within the context of appropriate stimuli, emotional intimacy, and ongoing arousal. This reconceptualization helps prevent the over-pathologization of women who may not experience spontaneous desire but are capable of becoming aroused under suitable conditions.

Compared to men, female sexual response is more strongly influenced by contextual and relational factors. The circular model proposed by Rosemary Basson emphasizes the central role of emotional intimacy, trust, and relational bonding in sexual motivation. Within this framework, the sustainability of sexual engagement depends not only on arousal but also on the experience being physically pleasurable and free of pain. Painful sexual experiences can disrupt this cycle, leading to avoidance and contributing to secondary loss of sexual desire.

Epidemiological data indicate that complaints of low sexual desire are common but do not necessarily indicate a clinical disorder. Findings from the PRESIDE study show that approximately 38.7% of women report low sexual desire, whereas only about 10% meet criteria for clinically significant distress associated with FSIAD. Similarly, although arousal difficulties are frequently reported, the proportion reaching clinical significance is considerably lower. Distress related to sexual difficulties tends to peak in midlife and decline in later years, possibly reflecting changes in expectations and the perceived importance of sexual activity.

In conclusion, the assessment of female sexual interest and arousal difficulties requires careful

consideration not only of symptom presence but also of contextual factors, relational dynamics, and the individual's subjective distress.

References

1. Basson, Rosemary. "Human sex-response cycles." Journal of Sex &Marital Therapy 27.1 (2001): 33-43. http://dx.doi.org/10.1080/00926230152035831
2. Basson, Rosemary. "The female sexual response: A different model." Journal of Sex &Marital Therapy 26.1 (2000): 51-65. https://doi.org/10.1080/009262300278641
3. Witherow-Párkányi, Márta. "Female sexual interest/arousal disorder: history of diagnostic considerations and their implications for clinical practice." Psychiatria Hungarica 37.2 (2022). https://www.researchgate.net/profile/Marta-Parkanyi-Witherow/publication/360716143_Female_sexual_interestarousal_disorder_history_of_diagnostic_considerations_and_their_implications_for_clinical_practice/links/643878fa4e83cd0e2fad3bca/Female-sexual-interest-arousal-disorder-history-of-diagnostic-considerations-and-their-implications-for-clinical-practice.pdf

Neurobiological Foundations and Clinical Reflections of Adult ADHD

Cenan Hepdurgun
Department of Psychiatry, Ege University Faculty of Medicine, Izmir, Türkiye

Attention-deficit/hyperactivity disorder (ADHD) was historically conceptualized as a childhood-onset condition, yet longitudinal evidence now establishes its persistence into adulthood in a substantial proportion of cases, with an estimated global adult prevalence of approximately 2.5% (Faraone et al. 2021). Adult ADHD poses a distinct diagnostic challenge: overt hyperactivity frequently recedes, while inattention, emotional dysregulation, and executive dysfunction dominate the clinical picture, often masked by comorbid mood, anxiety, and substance use disorders. A mechanistic framework that links clinical phenomena to underlying neurobiology is therefore essential for accurate formulation and rational treatment selection.
ADHD is among the most heritable neurodevelopmental disorders, with twin-based heritability estimates approaching 74% (Faraone et al. 2021). Large-scale genome-wide association studies have identified 27 risk loci and 76 candidate genes, with risk variants enriched in genes expressed during early brain development and in midbrain dopaminergic neurons (Demontis et al. 2023). This genetic architecture is extensively shared with other psychiatric disorders, offering a biological substrate for the transdiagnostic comorbidity observed clinically.
Catecholaminergic dysregulation — particularly altered tonic-phasic balance of dopamine (DA) and norepinephrine (NE) in prefrontal-striatal circuits — represents a convergent downstream consequence, providing the pharmacological target through which psychostimulants and selective NE reuptake inhibitors exert their therapeutic effects.
At the systems level, structural and functional neuroimaging identifies alterations in fronto-striatal, fronto-parietal, and cingulo-opercular networks, alongside atypical anti-correlation between the default mode network (DMN) and task-positive networks. Recent meta-analyses considering comorbid conditions report gray matter volume (GMV) reductions predominantly in frontal-parietal regions, limbic structures, and the corpus callosum, with maturational trajectories suggesting delayed cortical development (Fortea et al. 2024). These circuit-level findings provide a parsimonious account of core clinical phenomena: moment-to-moment attentional lapses reflect failed DMN suppression during goal-directed behavior; emotional dysregulation maps onto weakened amygdala-prefrontal connectivity; delay aversion and altered reinforcement sensitivity correspond to ventral striatal hypoactivation; and executive dysfunction emerges from fronto-parietal network inefficiency. Within this framework, stimulant response can be understood as pharmacological restoration of catecholaminergic signaling within these distributed circuits.

The clinical implications are threefold. First, phenotypic heterogeneity in adult ADHD reflects variable neurodevelopmental trajectories and differential engagement of specific neural networks, arguing against a unitary disease model. Second, high rates of comorbidity with mood, anxiety, and substance use disorders may reflect shared genetic and circuit-level vulnerabilities rather than independent conditions (Demontis et al. 2023). Third, an individualized treatment strategy integrating pharmacological, psychotherapeutic, and psychoeducational interventions — informed by a mechanistic formulation of each patient's presentation — offers the most promising path toward improved outcomes. Translating neurobiological insights into routine clinical practice remains an active frontier in contemporary psychiatry.

References

1. Demontis D, Walters GB, Athanasiadis G, et al. (2023) Genome-wide analyses of ADHD identify 27 risk loci, refine the genetic architecture and implicate several cognitive domains. Nat Genet, 55:198-208.
2. Faraone SV, Banaschewski T, Coghill D, et al. (2021) The World Federation of ADHD International Consensus Statement: 208 evidence-based conclusions about the disorder. Neurosci Biobehav Rev, 128:789-818.
3. Fortea L, Ortuño M, De Prisco M, et al. (2024) Atlas of gray matter volume differences across psychiatric conditions: A systematic review with a novel meta-analysis that considers co-occurring disorders. Biol Psychiatry, 98:76-90.

The Role of the Psychiatrist in the Digital Age: Ethical Responsibilities and Clinical Implications
The Digital Visibility of Psychiatrists: The Boundaries Between Informing, Psychoeducation, and Popularization

Merve Metin Abudalal
Department of Psychiatry, Başkent University Istanbul Hospital

In the digital age, the role of the psychiatrist has extended beyond traditional clinical boundaries. Today, psychiatrists are not merely physicians conducting individual patient evaluations but have also become actors who produce, interpret, and disseminate information on digital platforms, thereby influencing broad audiences (Torous & Roberts, 2017). While this transformation offers significant opportunities for increasing mental health literacy and reducing stigma, it also raises new boundary issues (Naslund et al., 2016).

To understand psychiatrists' digital visibility, it is important to distinguish between information dissemination, psychoeducation, and popularization. Information dissemination involves the neutral transmission of scientific and generally accepted knowledge and does not involve direct clinical intervention (American Medical Association, 2015). Psychoeducation, on the other hand, is an approach that connects with the individual's lived experience and aims to increase awareness. However, this area represents the point where boundaries are most permeable, as it may be perceived by the audience as a personal evaluation (Demers & Sullivan, 2016). Popularization, on the other hand, emerges when content becomes focused on visibility and engagement rather than scientific accuracy, and may lead to the superficialization of mental health concepts (Naslund et al., 2016).

The key factor distinguishing psychiatrists from other mental health professionals is the medical authority they hold. The language used in digital settings can often be perceived by the audience not merely as informational, but as a diagnostic statement or treatment recommendation (General Medical Council, 2013). This situation can lead individuals to misdiagnose themselves and develop unrealistic expectations regarding treatment processes (American Psychological Association, 2017).

In this context, the most critical issue is the blurring of the line between information and intervention. Digital content does not establish a therapeutic relationship; however, it can have a therapeutic effect on the viewer (Kolmes, 2012). Additionally, the psychiatrist's digital presence can influence the therapeutic framework through means such as patients researching the therapist and the therapist inadvertently sharing information about themselves (Gabbard, 2014).

In conclusion, a psychiatrist's digital presence is not merely a form of communication but an area where clinical responsibility extends. Therefore, content produced on digital platforms must be evaluated within the framework of ethical and clinical responsibility (American Psychological Association, 2017).

References

1. American Medical Association. (2015). Professionalism in the use of social media.
2. American Psychological Association. (2017). Ethical principles of psychologists and code of conduct.
3. Demers, L. A., & Sullivan, J. J. (2016). Ethical considerations in online mental health content.
4. General Medical Council. (2013). Doctors' use of social media.
5. Naslund, J. A., Aschbrenner, K. A., Marsch, L. A., & Bartels, S. J. (2016). The future of mental health care: Peer-to-peer support and social media.
6. Torous, J., & Roberts, L. W. (2017). The ethical use of mobile health technology in clinical psychiatry.

The Relationship Between Emotion and Cognitive Structure

Emine Yavuz[1], Vesile Şentürk Cankorur[2]
[1] Etlik City Hospital, Ankara, Turkey
[2] Department of Psychiatry, Ankara University Faculty of Medicine, Ankara, Turkey

Emotion is a multifaceted process involving physiological, cognitive, and behavioral components. Contemporary psychological and neurobiological frameworks have moved beyond viewing emotion and cognition as separate domains, instead emphasizing their functional integration. From this perspective, emotional states are not merely reactions; rather, they are fundamental processes that shape cognitive architecture and guide the allocation of mental resources.At the neurobiological level, emotion–cognition interactions are mediated by dynamic and reciprocal communication between limbic and cortical systems. The amygdala, hippocampus, and prefrontal cortex play central roles in detecting emotionally significant stimuli, encoding their contextual features, and regulating behavioral responses. Recent network-based findings further suggest that these processes are supported by large-scale brain systems, particularly the salience network, default mode network, and executive control network, which operate in coordination according to task demands and the emotional significance of incoming information. Thus, emotion and cognition are not mediated by separate systems, but by integrated neural networks that shape the processing of internal states and external demands.Emotion also has a substantial influence on executive functions and decision-making. Mild positive affect may enhance cognitive flexibility and creative problem-solving, whereas intense negative emotions or chronic stress may consume shared neural resources, thereby reducing the cognitive capacity available for inhibition, updating, and task switching. In decision-making, emotional states influence risk evaluation through an “affect-as-information” mechanism, whereby current emotional experience serves as a heuristic for judging uncertainty and potential reward. Clinically, disturbances in this integration are observed across a range of psychiatric disorders within a transdiagnostic framework. Attention bias toward negative stimuli, overgeneral autobiographical memory, and maladaptive emotion regulation strategies such as rumination are common features of depression, anxiety, and trauma-related conditions. These patterns likely reflect disruptions in the reciprocal modulation between emotional and cognitive neural systems. A clearer understanding of these interactions is essential for the development of targeted therapeutic approaches that address both the emotional and cognitive dimensions of mental health.

References

1. Pessoa L. The network model of the emotional brain. Trends Cogn Sci. 2017;21(5):357–371. doi: 10.1016/j.tics.2017.03.002
2. Zhang JX, Bo K, Wager TD, Gross JJ. The brain bases of emotion generation and emotion regulation. Trends Cogn Sci. 2025;29(10):879–891. doi:10.1016/j.tics.2025.04.013.

Silenced Before the Clinic: When Patients Never Become Cases

Kerem Zengin
Department of Psychiatry, Bakırköy Prof. Dr. Mazhar Osman Mental Health and Neurological Diseases Training and Research Hospital, Istanbul

A substantial number of people experiencing psychological distress never reach psychiatric care. Despite the high global burden of mental disorders, the treatment gap remains considerable. This gap cannot be explained solely by limited availability or accessibility of services. In many cases, help-seeking does not occur even when services are accessible. Low perceived need for treatment and the preference to manage difficulties independently are among the most frequently reported reasons for not seeking help (Andrade ve ark. 2014).
Stigma plays a central role in this process. It can be considered at different levels, including public stigma and self-stigma, as well as stigma related to mental health problems and stigma related to help-seeking. Help-seeking self-stigma refers to the internalization of negative beliefs about receiving professional support, which may threaten a person's sense of autonomy and competence (Hinshaw ve Stier 2022). In clinical practice, this rarely appears as a direct refusal. More often, it presents as delay, avoidance, or indirect forms of contact.
Stigma is not limited to attitudes; it also affects behavior. It has been shown that higher levels of stigma are associated with lower levels of active help-seeking (Schnyder ve ark. 2017). This creates a gap between recognizing distress and acting on it. People may acknowledge their difficulties but still avoid psychiatric care due to concerns about social consequences, professional implications, or being labeled.
From a clinical perspective, those who do not present to psychiatric services are not entirely absent from the healthcare system. They often appear in other settings such as primary care, emergency departments, or informal consultations. These encounters provide important opportunities for engagement, but they also raise practical and ethical questions, especially when patients seek help without formal registration, avoid documentation, or describe their complaints in non-psychiatric terms.
This presentation focuses on patients who remain outside formal psychiatric care despite significant psychological distress. It aims to examine the factors that prevent help-seeking and to discuss how clinicians can respond when contact occurs indirectly. Shifting attention from those who present to those who do not may help us better understand a less visible but clinically important part of psychiatric practice.

References

1. Andrade LH, Alonso J, Mneimneh Z, Wells JE, Al-Hamzawi A, Borges G ve ark. (2014) Barriers to mental health treatment: results from the WHO World Mental Health surveys. Psychol Med 44: 1303–1317.
2. Schnyder N, Panczak R, Groth N, Schultze-Lutter F (2017) Association between mental health-related stigma and active help-seeking: systematic review and meta-analysis. Br J Psychiatry 210: 261–268.
3. Hinshaw SP, Stier A (Ed) (2022) The Cambridge Handbook of Stigma and Mental Health. Cambridge, Cambridge University Press.

Clinical Evaluation and Treatment of Female Sexual Interest/Arousal Disorder

Bengü Yücens, M.D.
Pamukkale University Faculty of Medicine, Department of Psychiatry

Female Sexual Interest/Arousal Disorder (FSIAD) is a multidimensional condition characterized by a marked decrease in sexual interest and/or arousal, leading to clinically significant distress. Therefore, the evaluation and treatment process should be addressed within a biopsychosocial framework.

Clinical assessment begins with a detailed and structured history-taking process. In this process, it should be determined whether the problem is primary or secondary, and situational or generalized. Sexual desire (frequency of fantasies, response to erotic stimuli, initiation of sexual activity), sexual arousal (lubrication, arousal process, distractibility), and accompanying sexual dysfunctions (difficulty achieving orgasm, pain) should be systematically evaluated. In addition, partner relationship, marital conflicts, partner's sexual functioning, and relationship satisfaction should be assessed. Psychological factors (self-esteem, body image, performance anxiety), stressful life events, sexual myths, and history of trauma are also important domains that may influence the clinical picture. Furthermore, hormonal conditions (menopause, postpartum period), physical illnesses, psychiatric comorbidities, and medications used should always be taken into consideration.

The use of standardized scales supports the diagnostic process. The Female Sexual Function Index (FSFI) evaluates different domains of sexual functioning, while the Female Sexual Distress Scale-Revised (FSDS-R) measures the distress component required for diagnosis. The combined use of these two scales is important in terms of DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition) diagnostic criteria. In addition, the Golombok-Rust Inventory of Sexual Satisfaction and the Arizona Sexual Experiences Scale (ASEX) provide both individual- and couple-focused assessment.

The main approach in treatment is to target the underlying causes. Psychoeducation includes providing information about sexual anatomy and physiology, explaining the sexual response cycle, and correcting sexual myths. Cognitive behavioral therapy (CBT) and sex therapy techniques focus on enhancing self-esteem, reducing performance anxiety, and improving body awareness. Techniques such as sensate focus exercises, mindfulness-based attention practices, and masturbation exercises are effective in increasing sexual arousal and pleasure. In addition, strengthening communication with the partner and improving relationship satisfaction are important components of treatment.

Pharmacological treatment options are limited but may be used in certain cases. Flibanserin

and bremelanotide are FDA (Food and Drug Administration)-approved agents for increasing sexual desire. Among hormonal treatments, testosterone has been found to be effective, particularly in postmenopausal women. Local estrogen therapies and dehydroepiandrosterone (DHEA) are beneficial in cases of arousal difficulties associated with vaginal atrophy. Additionally, some agents such as bupropion and buspirone may be used off-label in selected cases.

In conclusion, the management of FSIAD should be planned in a multidisciplinary and individualized manner; psychotherapeutic approaches should be prioritized and supported with pharmacological treatments when necessary.

References

1. How A, Jowdy C, Novatcheva E, Clayton AH. Novel Pharmacologic Treatments of Female Sexual Dysfunction. Clin Obstet Gynecol. 2025 Mar 1;68(1):10-14. doi: 10.1097/GRF.0000000000000922.
2. Metz, M., Epstein, N., & McCarthy, B. (2017). Cognitive-Behavioral Therapy for Sexual Dysfunction (1st ed.). Routledge.
3. Toledo RG, Winkelman WD, Reyes-Gonzalez D, Bergeron S, Fladger A, Hacker MR, Anand M. Female Sexual Desire, Arousal, and Orgasmic Dysfunctions: A Systematic Review and Meta-Analysis of Treatment Options. J Minim Invasive Gynecol. 2026 Jan;33(1):16-33.e3. doi: 10.1016/j.jmig.2025.06.004.

Early Forced Marriage:
Chronic Trauma and Clinical Reflections

Gizem Çağla Aktaş
Cizre Dr. Selahattin Cizrelioğlu Devlet Hastanesi

Early forced marriage represents a form of chronic and developmental trauma, characterized by prolonged exposure to coercion, loss of autonomy, and repeated disruptions of normative developmental processes. Unlike single-incident trauma, its effects are cumulative and deeply embedded in the individual's emotional regulation, identity formation, and relational functioning. The persistence of such conditions often results in a sustained state of vulnerability that extends into later developmental stages and adulthood, affecting multiple domains of functioning.

Individuals exposed to early forced marriage frequently present with complex psychiatric manifestations, including affect dysregulation, dissociation, difficulties in identity development, and disturbances in interpersonal relationships. These clinical presentations are shaped by ongoing exposure rather than a single traumatic event, requiring a broader and more nuanced clinical perspective. In this sense, early forced marriage can be understood not only as trauma but also as a disruption of developmental continuity and integration of the self.

Within this context, some clinical presentations may also be associated with unrecognized experiences of loss related to disrupted developmental processes. Although these experiences may not be explicitly articulated, they can subtly influence the individual's internal world, self-perception, relational expectations, and sense of continuity over time.

This presentation aims to examine early forced marriage within a trauma-informed clinical framework, focusing on its manifestations in psychiatric practice. Through clinical reflections, it explores how prolonged exposure to coercion and loss of autonomy shapes symptom formation, identity development, and relational patterns over time. It also considers how these experiences may influence engagement with psychiatric care, help-seeking behavior, and therapeutic processes in different clinical contexts.

The presentation emphasizes the need for a more integrative clinical approach that takes into account the complexity of early forced marriage beyond a single diagnostic framework. Such an approach allows for a more comprehensive understanding of the patient's experience and supports more sensitive, context-aware, and effective psychiatric care.

References

1. Herman JL. Trauma and Recovery: The Aftermath of Violence—From Domestic Abuse to Political Terror. New York: Basic Books; 1992.
2. van der Kolk B. The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma. New York: Viking; 2014.

Invisible Body Under a Psychotic Diagnosis

Gizem Çağla Aktaş
Cizre Dr. Selahattin Cizrelioğlu Devlet Hastanesi

Stigma in psychiatry is commonly framed as a societal issue; however, it is also reproduced within clinical practice through diagnostic processes, clinical language, and interprofessional interactions. These processes often operate implicitly and may remain unrecognized, yet they can directly influence access to care, clinical decision-making, and treatment outcomes. Therefore, stigma should not be considered solely as a product of social attitudes, but also as a dynamic embedded within the structure and functioning of clinical practice itself.

Patients with psychotic disorders are particularly vulnerable to a phenomenon known as diagnostic overshadowing, in which physical symptoms are attributed to the psychiatric condition and therefore remain insufficiently investigated. In clinical encounters, bodily complaints are frequently interpreted as extensions of the mental state, which may lead to the minimization or dismissal of somatic concerns. Consequently, underlying medical conditions may be overlooked or their diagnosis delayed. Within this process, the patient's body gradually becomes "invisible"-not because it is absent, but because it is not adequately acknowledged. This invisibility cannot be explained solely by individual bias. It is also shaped by habitual modes of clinical reasoning, prioritization of diagnosis, time constraints, structural characteristics of healthcare systems, and hierarchical relationships between medical disciplines. When the psychiatric diagnosis becomes the dominant interpretative framework, both bodily symptoms and the patient's subjective experience may be reduced to a narrow lens. This reduction risks defining the patient primarily through diagnosis, limiting a more comprehensive understanding of their condition.

This presentation aims to conceptualize stigma not only as an external social phenomenon but also as a process reproduced within everyday clinical practice. Through a case-based discussion, it explores how clinical approaches to patients with psychotic disorders are shaped and how the body may become marginalized in this context. The ethical implications of overlooking bodily experience, as well as its impact on the patient–clinician relationship, will also be addressed.

The presentation ultimately emphasizes the need for a more integrative clinical approach that recognizes both psychic and bodily dimensions of the patient. Moving beyond a reductionist

understanding of diagnosis is essential for minimizing stigma and for providing more comprehensive and equitable healthcare.

References

1. Corrigan PW, Watson AC. Understanding the impact of stigma on people with mental illness. World Psychiatry. 2002;1(1):16–20.
2. Henderson C, Noblett J, Parke H, et al. Mental health-related stigma in health care and mental health-care settings. The Lancet Psychiatry. 2014;1(6):467–482.
3. Jones S, Howard L, Thornicroft G. Diagnostic overshadowing: worse physical health care for people with mental illness. Acta Psychiatrica Scandinavica. 2008;118(3):169–171.

Emotion on the pathway to psychosis

Simge Uzman Özbek
Department of Psychiatry, Dokuz Eylül University Faculty of Medicine, İzmir, Türkiye

It is well-established that psychotic disorders are not limited to delusions and hallucinations, but also involve impairments across cognitive, social, and emotional domains. In recent years, emotional processes have gained increasing attention as a core dimension of psychosis rather than a secondary or accompanying feature. Emotion comprises several interrelated subdomains, including emotional experience, emotional expression, emotion recognition, emotion regulation, and emotional awareness. These functions are closely linked with social cognition and play a central role in how individuals interpret internal states, understand others, and respond to interpersonal situations. Deficits in these areas have been shown to substantially impair psychosocial functioning in individuals with psychosis.

Importantly, emotional dysfunction has been identified not only in individuals with psychotic disorders but also in those at clinical high risk for psychosis. This suggests that disturbances in emotional functioning may reflect an early vulnerability marker and may emerge before the full clinical onset of illness. At the same time, emotional abnormalities should not be conceptualized solely as premorbid features. They may also arise as a consequence of clinical symptoms and persist over time as relatively stable, trait-like components of the disorder. For these reasons, emotional dysfunction is particularly relevant to understanding both the development and the longitudinal course of psychosis.

Maladaptive emotion regulation strategies have been associated with greater symptom severity, poorer psychosocial functioning, and increased difficulty coping with daily stress. Similarly, impairments in emotional awareness and in the recognition of others' emotions may contribute to social withdrawal, interpersonal misunderstanding, and reduced functional capacity. These findings indicate that emotional dysfunction in psychosis is multidimensional and clinically meaningful.

In conclusion, emotional disturbances have a central place in both the prodromal and chronic phases of psychosis. They should be regarded not merely as epiphenomena, but as core components that are directly related to the emergence, maintenance, and outcome of psychotic disorders. Accordingly, clinical interventions should move beyond a narrow symptom-focused perspective and incorporate strategies that directly target emotional processes. Such an approach may contribute to a more comprehensive understanding of psychosis and support more effective and functionally meaningful interventions.

References

1. Kimhy D, Gill KE, Brucato G ve ark. The impact of emotion awareness and regulation on social functioning in individuals at clinical high risk for psychosis. Psychol Med 2016;46(14):2907-2918.
2. Ludwig L, Werner D, Lincoln TM. The relevance of cognitive emotion regulation to psychotic symptoms: A systematic review and meta-analysis. Clin Psychol Rev 2019;72:101746.
3. Green MF, Horan WP, Lee J. Nonsocial and social cognition in schizophrenia: current evidence and future directions. World Psychiatry 2019;18(2):146-161.

Treatment of Depression in Individuals at High Risk for Bipolar Disorder

Simge Uzman Özbek
Department of Psychiatry, Dokuz Eylül University Faculty of Medicine, İzmir, Türkiye

Individuals at high risk for bipolar disorder are those who have not yet received a diagnosis of bipolar disorder but have an increased likelihood of developing the disorder because of their clinical characteristics and family history. This population is not defined solely by family history; rather, it is identified through the combined evaluation of multiple features, including subthreshold manic symptoms, temperament traits (e.g., cyclothymic temperament), recurrent depressive episodes, early-onset affective symptoms, and a history of recurrent depression. It has been shown that in young people at familial risk for bipolar disorder who also present with depression, anxiety, mood fluctuations, and subthreshold manic symptoms, the risk of transition to bipolar disorder may approach 50%. Therefore, high risk for bipolar disorder should be understood as a clinical pattern that cannot be reduced to a single symptom and requires longitudinal assessment.

Retrospective studies show that, in many individuals eventually diagnosed with bipolar disorder, the first clinical presentation is depression. Although the diagnosis of bipolar disorder is based on a history of mania or hypomania, early manifestations in many individuals are subtler, less specific, and often intertwined with depressive symptoms. Disturbances in sleep, reduced or fluctuating energy, attentional difficulties, restlessness, loss of interest, social withdrawal, and decline in functioning may all be part of this early phase. Especially in young people, such symptoms may be interpreted as developmental features, stress responses, or personality traits, making the underlying vulnerability to bipolar disorder easy to overlook. Depressive symptoms observed in individuals at high risk for bipolar disorder should therefore not be considered only within the framework of unipolar depression, but also as possible early indicators of a process that may evolve into bipolar disorder.

Current evidence supports planning the treatment of depression in individuals at high risk for bipolar disorder through an approach that takes into account symptom severity, functional impairment, and co-occurring risk features, and that may include psychotherapy, family-focused interventions, and, when indicated, pharmacotherapy. When pharmacological treatment is considered, the risk of a switch to mania or hypomania with antidepressant use should be carefully taken into account, and the process should be managed under close clinical monitoring. Accordingly, the treatment of depression in individuals at high risk for bipolar disorder requires a balanced approach that not only aims to reduce symptoms, but also considers the possible longitudinal course of the illness, emphasizes close follow-up, and is based on individualized clinical decision-making.

References

1. Ratheesh A, Hammond D, Watson M ve ark. Bipolar at-risk criteria and risk of bipolar disorder over 10 or more years. JAMA Netw Open 2023;6(9):e2334078.
2. Del Favero E. The management of prodromal symptoms of bipolar disorder: Available options and future perspectives. Medicina (Kaunas) 2021;57(6):1-23.
3. Cremaschi L, Macellaro M, Girone N ve ark. The progression trajectory of bipolar disorder: results from the application of a staging model over a ten-year observation. J Affect Disord 2024;362:186-193.

Freedom, Conformity, and Fatigue

Gülşen Sanci Topuz
Derince Training and Research Hospital

In the contemporary neoliberal-postfeminist context, the discourse of freedom offered to women is often presented as a continuation of feminist achievements. However, rather than functioning as a collective political gain, this notion of freedom increasingly operates as a form of governance based on individual responsibility and self-regulation, ultimately producing structural fatigue. While the expansion of choices is frequently equated with increased freedom, freedom cannot be reduced to the mere availability of options; rather, it is defined by the capacity to refuse them. In neoliberal conditions, however, freedom becomes inseparable from the obligation to construct one's own life, transforming it from a right into a burden. Individuals are expected not only to choose, but to choose correctly, and to assume full responsibility for the outcomes.

As highlighted by Angela McRobbie, feminist gains are presented as already "taken into account" within popular culture, creating the illusion that gender equality has been achieved (McRobbie 2009). In this way, feminism is rendered unnecessary, and structural inequalities are reframed as individual challenges. This produces what McRobbie terms a "double entanglement," where neoliberal ideals of autonomy coexist with persistent normative expectations. Women are positioned as independent subjects while simultaneously remaining bound to traditional gender norms, rendering freedom itself inherently contradictory.

Moreover, contemporary power operates not through external authority but through internalized norms. Women are expected to continuously regulate themselves, making choices within predefined frameworks that remain largely unquestioned. Failure, therefore, becomes individualized: whether in relationships, motherhood, or professional life, shortcomings are interpreted as personal misjudgments rather than reflections of structural constraints. Within this framework, adaptation emerges as a central mechanism. No longer a neutral process of adjustment, adaptation becomes a normative demand, reinforced through continuous self-surveillance. Women are required to monitor their bodies, behaviors, and emotions in order to align with socially constructed expectations.

The discourse of empowerment further intensifies this dynamic by shifting attention away from collective struggle toward individual self-management. Women are expected to be productive, self-sufficient, and emotionally stable, thereby becoming the primary agents of their own regulation. Importantly, this process often occurs at the level of conscious awareness. Women may recognize the norms they conform to, yet continue to reproduce them, indicating that

ideology persists not through ignorance but through reflexive compliance.
Lauren Berlant's concept of "cruel optimism" is particularly useful in explaining this attachment (Berlant 2011). Women remain invested in ideals that ultimately exhaust them because these ideals promise a desirable life. Abandoning them would require relinquishing not only aspirations but also identity. These dynamics culminate in fatigue. As Byung-Chul Han argues, contemporary society has shifted toward a performance-based model in which individuals are driven by the imperative to constantly achieve (Han 2015). For women, this pressure is intensified by the persistence of care work and emotional labor, resulting in a double burden. This fatigue is not merely physical exhaustion but a structural condition that is often misrecognized as an individual failure, manifesting as burnout or depression. Such interpretations obscure its systemic origins. In conclusion, the contemporary configuration of freedom, adaptation, and fatigue calls for a critical rethinking of postfeminist subjectivity. The issue lies not in women's individual shortcomings, but in the structural conditions that shape their choices.

References

1. McRobbie A. The aftermath of feminism: Gender, culture and social change. London: Sage Publications; 2009.
2. Berlant L. Cruel optimism. Durham: Duke University Press; 2011.
3. Han BC. The burnout society. Stanford: Stanford University Press; 2015.

From Thought to Action: The Neurobiology of Suicide

Koray YARIZ[1, 2]
[1]Kırıkkale Yüksek İhtisas Hospital, Department of Psychiatry
[2] Hacettepe University, Institute of Neurological Sciences and Psychiatry

Suicide is a complex and multi-layered process that cannot be explained solely by individual psychopathology or environmental stressors. Contemporary approaches conceptualize suicidal behavior not through isolated biological systems, but within a dynamic and integrated framework encompassing genetic, neurochemical, neuroinflammatory, and brain network-level processes. In particular, the transition “from thought to action” is considered a critical outcome emerging from the interaction of these multi-level systems.

Traditionally, suicidal behavior has been associated with serotonergic system dysfunction, impulsivity, and aggression. However, current literature indicates that this perspective is insufficient. Dysregulations in dopaminergic and especially glutamatergic systems contribute to risk through their roles in reward processing, decision-making, and cognitive flexibility. Mechanisms regulating the glutamate–GABA balance and neuroplasticity have gained a more central role, particularly in light of clinical findings from rapid-acting treatments such as ketamine (1).

Another key emerging domain is neuroinflammation. Elevated levels of pro-inflammatory cytokines, microglial activation, and glial dysfunction influence both mood regulation and cognitive control processes, thereby increasing suicide risk (2). These findings suggest that suicidal behavior should be understood not only at the level of neurotransmission but also within the framework of immune–neural interactions.

Neuroimaging studies have demonstrated that suicidal behavior is associated not with isolated regional abnormalities but with disruptions in large-scale brain networks, particularly involving the prefrontal cortex, anterior cingulate cortex, and limbic structures. Reduced prefrontal control alongside increased limbic reactivity may result in impaired emotional regulation, heightened threat perception, and increased impulsivity. In this context, suicide is increasingly conceptualized as a “network disorder” (3).

An important contemporary distinction is that suicidal ideation and suicide attempts may not share identical neurobiological underpinnings. The transition from thought to action is thought to involve processes such as impulsivity, stress tolerance, fear desensitization, and behavioral disinhibition. This distinction introduces a new paradigm in clinical risk assessment.

Genetic predisposition plays a significant role through variations related to stress response and emotional regulation; however, its effects are meaningful primarily in interaction with

environmental factors. Dysregulation of the hypothalamic–pituitary–adrenal (HPA) axis and chronic stress responses constitute important biological substrates that increase vulnerability. In conclusion, the neurobiology of suicide should be understood as a multi-layered, network-based, and dynamic system. This integrative perspective offers new opportunities for identifying biomarkers, improving risk prediction, and developing targeted, rapid-acting treatment strategies. However, the translation of these findings into clinical practice remains limited, and further translational research is needed.

References

1. Can AT, Mitchell JS, Dutton M, Bennett M, Hermens DF, Lagopoulos J. Insights into the neurobiology of suicide: elucidating the role of glutamatergic systems through the lens of ketamine. Psychiatry Clin Neurosci. 2023;77:513–529. https://doi.org/10.1111/pcn.13572
2. Costanza A, Amerio A, Aguglia A, et al. Inflammatory pathology in depression and suicide: a mechanistic distillation of clinical correlates. Front Immunol. 2024;15:1479471. https://doi.org/10.3389/fimmu.2024.1479471
3. Chen VC, Chou YS, Tsai YH, et al. Resting-state functional connectivity and brain network abnormalities in depressive patients with suicidal ideation. Brain Topogr. 2021;34(2):234–244. https://doi.org/10.1007/s10548-020-00817-x

Consultation-Liaison Cooperation in Transplantation Psychiatry and Standardized Evaluation: The SIPAT Application

Erkin Can Bilgin
Specialist in Psychiatry, Department of Psychiatry, Ege University Faculty of Medicine Hospital

Organ transplantation remains the definitive and often life-saving intervention for patients suffering from end-stage organ failure. However, the scarcity of donor organs necessitates highly selective listing criteria to ensure optimal graft utility and long-term medical benefit. In this context, Consultation-Liaison (CL) psychiatry plays an indispensable role within the multidisciplinary transplant team. The CL psychiatrist is responsible for conducting comprehensive psychiatric evaluations, managing pre-existing or new-onset psychiatric comorbidities, and identifying psychosocial factors that could compromise post-operative recovery (Kumnig ve Jowsey 2016).

Historically, the psychosocial evaluation of transplant candidates has been challenged by a lack of uniformity and standardization across different transplant centers. Assessments often relied heavily on the subjective clinical judgment of individual evaluators, potentially leading to inconsistencies and biases in waitlisting decisions. To address this critical gap and promote equitable access to transplantation, objective and standardized instruments were needed. The Stanford Integrated Psychosocial Assessment for Transplantation (SIPAT) was developed precisely to fulfill this requirement and provide a structured framework for evaluation (Maldonado ve ark. 2012).

The SIPAT is a comprehensive, globally recognized, and validated quantitative tool designed to standardize the psychosocial assessment process. It systematically evaluates candidates across four core domains: Patient Readiness Level and Illness Management, Social Support System, Psychological Suitability and Psychopathology, and Lifestyle and Effect of Substance Use. By assigning a quantifiable numerical score based on the assessment of these domains, the SIPAT stratifies candidates into distinct risk categories ranging from excellent candidates to high-risk candidates. This stratification allows for a clear, objective representation of a patient's psychosocial vulnerability (Maldonado ve ark. 2012).

The implementation of the SIPAT significantly enhances CL cooperation. It fosters objective, data-driven decision-making and provides a common language for communication among the surgeons, hepatologists, nephrologists, and psychiatric professionals on the transplant committee. Rather than serving merely as a gatekeeping mechanism to exclude candidates, the CL psychiatrist utilizes the SIPAT to identify potentially modifiable vulnerabilities. Once these risk factors are identified, the CL team can implement targeted interventions, such as

psychoeducation, addiction counseling, optimization of psychotropic medications, and strengthening of social support networks.

Empirical evidence demonstrates that elevated total SIPAT scores and specific domain vulnerabilities are significantly associated with a lower likelihood of being waitlisted and with adverse post-transplant outcomes, including immunosuppression nonadherence, acute biopsy-proven rejection, and substance use relapse (Goel ve ark. 2022). By integrating the SIPAT into routine CL psychiatry practice, mental health professionals can proactively support high-risk patients, shifting the focus from passive evaluation to active pre-habilitation. This collaborative and standardized approach ultimately improves waitlisting equity, optimizes graft survival, and enhances the overall quality of life for organ transplant recipients.

References

1. Goel A, Patel YA, Lyles CR ve ark. (2022) The Stanford Integrated Psychosocial Assessment for Transplant is associated with outcomes before and after liver transplantation. Liver Transpl, 28:789-798.
2. Kumnig M, Jowsey SG (2016) Psychiatric assessment of candidates for solid organ transplantation. World J Psychiatry, 6:106-114.
3. Maldonado JR, Dubois HC, David EE ve ark. (2012) The Stanford Integrated Psychosocial Assessment for Transplantation (SIPAT): a new tool for the psychosocial evaluation of organ transplant candidates. Psychosomatics, 53:123-132.

Cognitive Behavioral Therapy Techniques and Strategies in Adult Attention-Deficit/Hyperactivity Disorder

Nilay Bilgin
Bornova Turkan Ozilhan State Hospital, Izmir, Turkiye

Adult Attention-Deficit/Hyperactivity Disorder (ADHD) is a neurodevelopmental condition characterized by significant impairments in executive functions, including organization, time management, and emotional regulation. While pharmacological interventions are foundational, Cognitive Behavioral Therapy (CBT) provides essential structured strategies to manage functional deficits. This summary outlines a modular CBT approach focusing on executive skill enhancement and cognitive restructuring.

The first module, Organization and Planning, emphasizes the externalization of executive functions. A core strategy is categorical prioritization via the Eisenhower Matrix, where tasks are classified into levels: A (Important/Urgent), B (Important/Not Urgent), and C (Unimportant). To bypass the "paralysis of choice," task decomposition is utilized, transforming vague goals into concrete actions of 5-15 minutes. This process facilitates top-down control by the prefrontal cortex. Patients are encouraged to adopt a "Single System" principle, using one integrated calendar for fixed appointments and a separate prioritized task list to reduce cognitive load. Environmental modifications, such as visual labeling and "open-shelf" organization, further sustain behavioral consistency.

The second module targets Distractibility Management through stimulus modulation. Physical, digital, and social distractors are minimized using noise-canceling tools and notification filters. To manage internal cognitive intrusions, the "Mental Parking" technique is employed, where impulsive thoughts are recorded for later review, thereby reducing the urgency felt by the patient. Structured time-blocking and planned breaks are integrated into the workflow. Rather than viewing breaks as rewards, they are treated as physiological necessities to reduce the stress load on the amygdala and hypothalamus. A "re-focusing bridge" is utilized to minimize cognitive friction when transitioning from a break back to a task.

The third module addresses Cognitive Restructuring and Procrastination. Negative Automatic Thoughts (NATs), such as "I can never be organized," are challenged by examining empirical evidence and developing functional alternatives. Self-coaching techniques help replace the "Harsh Internal Critic" with a "Rational Coach" persona. To combat procrastination, the "5-Minute Rule" is applied, based on the principle that initiation triggers the dopaminergic system, thereby generating motivation post-action. By gamifying progress through reward systems and focusing on "low-barrier" actions, patients can break the anxiety-avoidance cycle.

In conclusion, the integration of these behavioral modules and cognitive strategies allows adults with ADHD to externalize executive demands, reduce cognitive chaos, and rebuild self-efficacy in their personal and professional lives.

References

1. Safren SA, Sprich S, Perlman CA ve ark. Mastering Your Adult ADHD: A Cognitive-Behavioral Treatment Program Therapist Guide. 2. Baskı, New York, Oxford University Press, 2017.
2. Ramsay JR, Rostain AL. The Adult ADHD Tool Kit: Using CBT to Facilitate Coping Inside and Out. New York, Routledge, 2015.
3. Solanto MV. Cognitive-Behavioral Therapy for Adult ADHD: Targeting Executive Dysfunction. New York, The Guilford Press, 2011.

A GPT-Assisted Structured Discharge Summary Model for the Transition from Adolescent to Adult Psychiatry

Yiğit Özaydın
Dörtyol State Hospital, Department of Child and Adolescent Psychiatry, Hatay

The transition from adolescent to adult psychiatric care is clinically one of the most fragile thresholds in the continuity of mental health services. During this period, the patient undergoes not only a developmental shift but also a structural handover between two distinct clinical paradigms, service models, and documentation traditions. The discharge summary (in Turkish clinical practice, the epikriz) is the principal vehicle through which this handover takes place. Yet a considerable body of evidence, most notably the TRACK study and subsequent multi-perspective analyses, has shown that developmental history, longitudinal course, risk patterns, and the underlying logic of treatment are often inadequately transmitted across this interface, producing discontinuities that can adversely affect diagnostic coherence, treatment planning, and patient safety.

This presentation introduces a GPT-assisted structured discharge summary model developed specifically for the adolescent-to-adult psychiatric transition, and situates it within the current international literature on transition psychiatry and artificial intelligence (AI)-supported clinical documentation. The model is grounded in three design principles: (1) preservation of the developmental narrative and the clinical subject, so that the young person is not reduced to a cross-sectional diagnostic label at the moment of transfer; (2) standardisation of critical transition-relevant domains, including longitudinal symptom trajectory, risk history, psychosocial functioning, and therapeutic rationale; and (3) auditability, so that generated output remains traceable, clinician-reviewable, and open to correction.

The theoretical framing draws on the NICE guideline NG43, which conceptualises transition as a planned, person-centred process rather than an administrative event, and on recent work by Janota and Janota demonstrating that large language model–generated psychiatric discharge summaries can match or exceed clinician-authored documents in coherence and structural completeness, while still requiring expert oversight for clinical accuracy. Against this background, the proposed model is positioned not as an automation tool but as a decision-support framework intended to reduce transfer-related information loss while preserving clinical judgement.

Clinical vignettes will be used to illustrate the strengths and limitations of the model, including the risk of omission, the need for human verification, and considerations of data protection. Particular attention will be given to representational equity: young people across the full range

of gender identities, socioeconomic contexts, and presentations should be visible in the transferred narrative rather than flattened by templated language. The presentation will close with implementable recommendations for clinicians, service planners, and training programmes aiming to strengthen continuity of care across the adolescent–adult interface.

Keywords: transition psychiatry, discharge summary, large language models, continuity of care, adolescent mental health

References

1. Singh SP, Paul M, Ford T, Kramer T, Weaver T, McLaren S, et al. Process, outcome and experience of transition from child to adult mental healthcare: multiperspective study. Br J Psychiatry 2010;197(4):305-312.
2. National Institute for Health and Care Excellence. Transition from children's to adults' services for young people using health or social care services (NICE Guideline NG43). London: NICE; 2016.
3. Janota B, Janota K. Application of artificial intelligence (AI) in the creation of discharge summaries in psychiatric clinics. Int J Psychiatry Med 2025;60(3):330-337.

Suicide in Children and Adolescents: Contemporary Theoretical Models

Hazal Yağmur Yılancıoğlu
Bakırçay University Çiğli Training and Research Hospital, İzmir, Türkiye

In recent years, the leading approach to understanding suicidal thoughts and behaviors in children and adolescents has been the ideation-to-action framework, which is based on the assumption that the emergence of suicidal ideation and the transition from ideation to attempt are not the same process. Current studies focusing on adolescents indicate that the most widely examined models within this framework are the Interpersonal Theory of Suicide (IPTS), the Three-Step Theory (3ST), and the Integrated Motivational-Volitional Model (IMV). In particular, variables such as psychological pain, hopelessness, perceived burdensomeness, thwarted belongingness, and acquired capability appear to hold a central clinical role. Collectively, these theories emphasize that suicide risk cannot be explained solely by the severity of depressive symptoms; rather, it should be evaluated together with the individual's subjective experience of pain, hopelessness about the future, relational disconnection, and experiences that increase the capacity for self-harm (Kirshenbaum et al. 2024). The IPTS proposes that the desire for suicide develops primarily through perceived burdensomeness and thwarted belongingness, whereas progression to lethal suicidal behavior requires acquired capability. The 3ST argues that the combination of psychological pain and hopelessness gives rise to suicidal ideation, that a weakened sense of connectedness deepens this ideation, and that the capacity for suicide is the key determinant of action (Van Orden et al. 2010). The IMV model, in contrast, suggests that experiences of defeat and entrapment form the motivational core, while in the volitional phase, factors such as access to means, exposure to suicidal behavior, acquired capability, impulsivity, mental imagery, and past suicidal behavior increase the likelihood of an attempt.Contemporary suicide theories provide a framework that moves risk assessment in children and adolescents beyond a static symptom checklist and toward an understanding of the conditions under which suicidal thoughts are transformed into action. This perspective highlights the need for clinical assessment to address psychological pain, hopelessness, burdensomeness, belongingness, social context, and history of self-harm together (Yöyen and Keleş 2024).

References

1. Kirshenbaum JS, Pagliaccio D, Bitran A, et al. (2024) Why do adolescents attempt suicide? Insights from leading ideation-to-action suicide theories: a systematic review. Transl Psychiatry 14:266.
2. Van Orden KA, Witte TK, Cukrowicz KC, et al. (2010) The interpersonal theory of suicide. Psychol Rev 117:575-600.
3. Yöyen E, Keleş M (2024) First-and second-generation psychological theories of suicidal behaviour. Behav Sci (Basel) 14:710.

Contemporary Femininity Narratives: "Well-Groomed, Compliant, and Happy"

Elif Poyraz
Igdir Dr. Nevruz Erez State Hospital

This presentation examines emerging femininity narratives circulating on social media, focusing on four prominent archetypes: the "clean girl," high-functioning womanhood, tradwife (neo-domestic femininity), and slow/soft living cultures. While these trends appear to promote different lifestyles, ranging from productivity and optimization to domesticity and intentional slowness, they converge around a shared function: the production and normalization of idealized modes of being a woman.

The "clean girl" aesthetic emphasizes minimalism, controlled appearance, and an "effortless" yet highly curated lifestyle, often sustained by invisible labor and consumption. High-functioning femininity extends this logic into productivity, where women are expected to excel simultaneously in career, relationships, self-care, and emotional regulation. In contrast, the tradwife narrative valorizes domestic labor, caregiving, and relational harmony, framing fulfillment through family-centered roles. Meanwhile, slow living and soft living discourses promote rest, mindfulness, and intentionality, yet frequently become aestheticized and commodified ideals that require time, economic privilege, and performative consistency.

Despite their apparent differences, these narratives collectively construct new normative frameworks of femininity. They prescribe how women should look, feel, behave, and organize their lives, often masking structural inequalities by framing these expectations as individual choices or lifestyle preferences. As a result, they may contribute to internalized pressure, self-surveillance, and the invisibilization of fatigue, ambivalence, and psychological distress.

To conceptualize this phenomenon, the presentation draws on Michel Foucault's notion of internalized surveillance and Rosalind Gill's postfeminist framework. From a Foucauldian perspective, power operates not only through external constraints but through self-regulation, where individuals actively monitor and discipline themselves according to normative ideals (1). Gill's postfeminist sensibility further elucidates how contemporary femininity is shaped by a discourse of choice, empowerment, and self-improvement, while subtly reproducing gendered expectations in depoliticized forms (2, 3).

Finally, the presentation addresses the sociocultural and psychological conditions underpinning the popularity of these narratives. In a neoliberal context characterized by uncertainty and individual responsibility, such frameworks offer clear scripts for identity formation, control, and belonging. Social media platforms amplify these dynamics by rewarding visibility, aesthetic coherence, and performativity.

In conclusion, contemporary femininity narratives should not be understood merely as trends but as culturally embedded regulatory systems that shape women's subjectivities, behaviors, and mental health.

References

1. Foucault M. Discipline and Punish: The Birth of the Prison. New York: Pantheon Books; 1977.
2. Gill R. Postfeminist media culture: Elements of a sensibility. Eur J Cult Stud. 2007;10(2):147–166.
3. Gill R. The affective, cultural and psychic life of postfeminism: A postfeminist sensibility 10 years on. Eur J Cult Stud. 2017;20(6):606–626.

Psychiatric Evaluation and Process-Oriented Follow-up Approaches for Living Organ Donors

Selin Tanyeri Kayahan*
Yalvaç State Hospital, Ministry of Health of the Republic of Türkiye, Isparta

Living organ donation is an altruistic act in which the donor risks their own health, both physically and psychologically, for the sake of another. Living donors are a particularly important option for kidney and liver transplants. The most critical element of this process, from an ethical and medical perspective, is the preservation of the donor's health and well-being. The evaluation of potential donors should be based on the candidate's complete willingness, motivation, and level of knowledge about the surgical procedure. Clinical assessment meticulously examines the reasons for donation, the donor-recipient relationship, any potential pressure or financial gain, social support systems, psychiatric history, and personality traits. According to the legislation in Türkiye, organ transplants from living donors can be performed from the recipient's spouse, with whom they have been married for at least two years, and blood relatives or in-laws up to the fourth degree (including the fourth degree). If the disease requiring organ transplantation is diagnosed after marriage, the requirement of being married for at least two years is waived. For non-related donor transplants, approval from the Organ Transplantation Evaluation Ethics Committee is required. The literature indicates that mortality rates are low among donors, but loss of work capacity may occur for 4-6 weeks in kidney donors and 8-12 weeks in liver donors. Studies on liver donors report that quality of life generally returns to baseline approximately one year after surgery. However, it has been noted that organ donors may experience psychosocial challenges such as post-transplant depression, anxiety disorders, stress, and health-related concerns. In conclusion, psychiatric evaluation is crucial in the living organ transplant process. Key recommendations include ensuring donors understand the risks and provide informed consent, identifying pre-existing psychiatric conditions that increase surgical or psychiatric risk, detecting potential coercion, financial incentives, or ambivalence, and establishing intervention and monitoring programs to protect long-term mental health and quality of life after transplantation. A multidisciplinary approach centered on donor health is essential for the success of organ transplantation.

References

1. Noyan MA, Sertöz ÖÖ, Elbi H ve ark. (2011) Canlıdan organ naklinde ruhsal değerlendirme. Anatolian Journal of Psychiatry 12: 84-9.
2. Duman B, Kumbasar H (2026) Transplantasyon psikiyatrisi. Konsültasyon Liyezon Psikiyatrisi,
3. Baskı, Cilt 1, H Elbi, C Cimilli, Ö Önen Sertöz, Ç Karşıdağ, G Sözeri-Varma (Ed), Ankara, TPD Yayınları, s. 271-80.
3. Duerinckx N, Timmerman L, Van Gogh J ve ark. (2014) Predonation psychosocial evaluation of living kidney and liver donor candidates: a systematic literature review. Transpl Int 27(1): 2-18. https://doi.org/10.1111/tri.12154

A Multidisciplinary Approach to Sexual Abuse Cases Encountered in Outpatient Settings: A Model Discussion

Ezgi Karakaya Hacır
Specialist Physician, Şırnak Şehit Aydoğan Aydın State Hospital

This working group addresses the clinical approach to cases of sexual abuse and violence encountered in outpatient psychiatric settings. Structured as an interactive and case-based session, it aims to create a space for discussing how psychiatrists can respond effectively when individuals presenting to the clinic disclose, or are found to be experiencing, sexual abuse or violence. The session focuses on practical questions that arise in everyday clinical practice, including how to recognize, assess, and manage these cases in a way that prioritizes patient safety, trust, and continuity of care.

Using illustrative case examples, participants will explore key aspects of clinical assessment, including how to inquire about abuse sensitively, how to respond to disclosure, and how to evaluate immediate and longer-term risks. Attention will be given to establishing a therapeutic alliance, maintaining a supportive and nonjudgmental stance, and navigating the emotional and relational dynamics that often accompany such encounters. The discussion will also consider how to balance clinical responsibilities with ethical considerations such as confidentiality, patient autonomy, and protection from harm.

A central component of the session is the shared reflection on “what to do” in concrete clinical situations. Participants will be encouraged to discuss their own experiences, uncertainties, and challenges, fostering a collaborative environment where different approaches can be examined. The role of coordination with other services, including social support systems and relevant institutional resources, will be addressed in terms of practical pathways rather than procedural detail.

By grounding the discussion in real clinical scenarios, this working group aims to move beyond theoretical knowledge and offer a clinically relevant, experience-based perspective. The overall goal is to support psychiatrists in developing a clearer, more confident approach to managing sexual abuse and violence cases in outpatient practice, with an emphasis on patient-centered and safe care.

Being a Woman in Contemporary Conflict Zones: Shared Experiences from Gaza and Rojava

Ezgi Karakaya Hacır
Specialist Physician, Şırnak Şehit Aydoğan Aydın State Hospital

This presentation explores what it means to be a woman in contemporary conflict zones, focusing on Gaza and Rojava through the lens of lived experience. It highlights the shared, everyday realities that shape women's lives in conditions of war.

Drawing on humanitarian reports and field-based narratives, the talk examines how armed conflict deepens pre-existing gender inequalities and creates overlapping forms of vulnerability. In Gaza, for instance, ongoing displacement, the collapse of healthcare systems, and severe shortages of food, water, and shelter have profoundly affected women's daily lives. Nearly half of the displaced population consists of women and girls, and the conditions of overcrowded shelters, lack of privacy, and weakened social protection mechanisms significantly increase the risk of gender-based violence. At the same time, many women remain unable or unwilling to seek support due to stigma, insecurity, and the prioritization of survival needs.

Personal accounts further illustrate the depth of these challenges. Pregnant women, for example, face severe barriers to accessing maternal healthcare, with many unable to reach functioning hospitals or receive adequate prenatal care. In some cases, childbirth occurs in unsafe conditions without proper medical assistance, reflecting the broader collapse of essential services. These experiences highlight how war reshapes even the most fundamental aspects of life, including pregnancy, caregiving, and bodily autonomy.

Similar experiential patterns can be observed in other conflict-affected settings such as Rojava. Women navigate instability, loss, and disrupted community structures while assuming expanded caregiving roles under conditions of scarcity. Despite differences in local dynamics, everyday life in both contexts is marked by uncertainty, limited access to essential resources, and heightened exposure to violence, exploitation, and economic precarity.

By bringing these two cases into dialogue, this presentation argues that war generates shared gendered experiences that transcend regional differences. Women are not only disproportionately affected by conflict but are also central to the maintenance of daily life under crisis conditions. Their roles as caregivers, providers, and community actors become more pronounced as formal systems weaken or collapse.

Ultimately, the presentation emphasizes the importance of recognizing both vulnerability and agency in understanding women's experiences of war. Such an approach is essential for informing more effective, inclusive, and gender-sensitive responses in humanitarian contexts, as well as for supporting longer-term recovery processes.

References

1. Physicians for Human Rights Israel. (2026). Motherhood under fire: How much can a woman endure?
2. United Nations Population Fund (UNFPA). (2025). Gender-based violence (GBV) snapshot: Gaza (December 2024–March 2025).

Rethinking diagnostic boundaries from a translational perspective: Genomic overlap between psychiatry and metabolic conditions

Giuseppe Fanelli
Department of Medicine, University of Udine, Udine, Italy
Department of Human Genetics, Radboud university medical center, Nijmegen, The Netherlands

Psychiatrists deal every day with the consequences of an artificial separation between mental and physical illness. Cardiometabolic disease remains one of the main contributors to premature mortality in people with psychiatric disorders, yet metabolic abnormalities are still often framed as secondary issues, attributed mainly to unhealthy lifestyle or psychotropic exposure. This lecture will argue that such a view is incomplete. A growing body of epidemiological, biological, and genomic evidence indicates that at least part of the overlap between psychiatric disorders and insulin resistance-related conditions reflects shared pathophysiology rather than simple comorbidity. The lecture will first address why this issue should matter to practicing psychiatrists. Insulin resistance, type 2 diabetes, obesity, and metabolic syndrome cluster across multiple psychiatric conditions and may worsen prognosis, cognitive performance, symptom burden, treatment outcomes, and mortality. Although psychotropic drugs are highly relevant to metabolic risk, disturbances in glycaemic and insulin-related pathways can also be detected early in illness, including in the absence of prolonged pharmacological exposure. The second part will focus on mechanisms. I will discuss insulin signalling not only as a peripheral metabolic pathway, but also as a brain-relevant system involved in neuroinflammation, neurotransmission, synaptic plasticity, reward processing, and cognition. I will then present evidence from genome-wide association study-based analyses showing that major psychiatric disorders share inherited liability with insulin resistance-related phenotypes at both global and local genomic levels. These data indicate that the direction of shared genetic effects is not uniform across disorders and that biologically relevant overlap may exist even when no genome-wide correlation is detected. I will also present recent multivariate findings supporting a latent genetic factor spanning both psychiatric and metabolic phenotypes, together with links to brain morphometry, brain and pituitary tissue expression, immune-inflammatory pathways, insulin signalling, lipid metabolism, and candidate drug targets. Finally, I will discuss the clinical implications of this translational framework. If part of psychiatric-metabolic multimorbidity is biologically rooted, then metabolic screening in psychiatry is not enough on its own. We need metabolically informed prescribing, earlier risk stratification, and treatment models that integrate psychiatric and physical health from the

outset. I will also discuss why this framework may support drug repurposing strategies, including the growing interest in glucagon-like peptide-1 receptor agonists, while keeping claims aligned with the current evidence base. Overall, this lecture proposes that revisiting diagnostic boundaries through genomics may help psychiatry move toward more valid disease models and more useful clinical decisions.

References

1. Fanelli G, Franke B, De Witte W, Ruisch IH, Haavik J, van Gils V, et al. Insulinopathies of the brain? Genetic overlap between somatic insulin-related and neuropsychiatric disorders. Transl Psychiatry. 2022;12(1):59. doi:10.1038/s41398-022-01817-0.
2. Fanelli G, Franke B, Fabbri C, Werme J, Erdogan I, De Witte W, et al. Local patterns of genetic sharing between neuropsychiatric and insulin resistance-related conditions. Transl Psychiatry. 2025;15:145. doi:10.1038/s41398-025-03349-9.
3. Fanelli G, Bralten J, Franke B, Mota NR, Atti AR, De Ronchi D, et al. Insulin resistance and poorer treatment outcomes in depression: evidence from UK Biobank primary care data. Br J Psychiatry. 2025:1-10. doi:10.1192/bjp.2025.82.

Are Males with ADHD 'from Mars' and Females 'from Venus'? A Critical Look at the Clinical Presentation of ADHD in Women.

Ozge Kılıç
Bezmialem Vakıf University, Institute of Health Sciences, Department of Neurosciences, Istanbul, Türkiye

There are a vast number of difficulties in the life of an individual with attention deficit hyperactivity disorder (ADHD). Difficulties boil down to different constructs in females and males, and interventions need to take these differences into account.
As the child and adolescent grow into adulthood, the core symptoms of ADHD change in manifestation. Symptom changes overlap with the process of identity formation, personality changes, hormonal influences and transitions, societal expectations, and cognitive processing of recent and past life events, which all contribute to the presentation of the disorder.
The long predominant association of ADHD with males often leads to less referral of females to clinics. ADHD diagnosis demands a nuanced evaluation. Furthermore, the co-occurring psychiatric disorders diagnosed during standard evaluations may not help to identify the multifaceted nature of ADHD. Therefore, all lead to underdiagnosis, misdiagnosis or late diagnosis of ADHD in females.
The manifestation of ADHD in women includes internalised symptoms such as inattentiveness and emotional dysregulation. Women frequently develop compensatory strategies, hyper-vigilance toward social cues, perfectionistic coping, and may try to fit in, agree, or over-please in relationships. These adaptive behaviours may be socially functional in the short term, but in time come with a social cost. Ongoing ‘masking’ is related to a delay in diagnosis and increases the vulnerability to anxiety disorders, major depression, eating disorders, and self-harm behaviours.
This presentation aims to contribute to a more comprehensive understanding of ADHD, fostering improved recognition and tailored strategies to support both males and females who suffer from this condition.

References

1. Young S, Adamo N, Ásgeirsdóttir B. B, Branney P, Beckett M, Colley W, Cubbin S, Deeley Q, Farrag E, Gudjonsson G, Hill P, Hollingdale J, Kilic O, Lloyd T, Mason P, Paliokosta E, Perecherla S, Sedgwick J, Skirrow C, … Woodhouse E (2020). Females with ADHD: An expert consensus statement taking a lifespan approach providing guidance for the identification and treatment of attention-deficit/ hyperactivity disorder in girls and women. BMC Psychiatry, 20(1), 404

2. Young, S., Uysal, O., Kahle, J., Gudjonsson, G. H., Hollingdale, J., Cortese, S., Sakalli-Kani, A., Greer, B., Cocallis, K., Sylver, N., Yilmaz, U. E., Semerci, B., & Kilic, O. (2024). A systematic review and meta-analysis comparing the severity of core symptoms of attention-deficit hyperactivity disorder in females and males. Psychological Medicine, 54(14), 3763–3784.

Clinical and Examination Findings in the Differential Diagnosis of Late-Onset Depression and Dementia

Damla Aslan Kirazoğlu
Psychiatry Clinic, Bakırköy Mazhar Osman Training and Research Hospital for Psychiatry, Neurology and Neurosurgery

Due to the clinical similarity between depression and dementia in older adults, a significant number of depressed patients present to outpatient clinics with suspected dementia. Conversely, depressive states associated with dementia may be misdiagnosed as depression, leading to prolonged and potentially inappropriate antidepressant treatment. Since depression and dementia differ fundamentally in their treatment strategies and disease courses, careful differentiation between the two is essential in the clinical management of dementia [1].
From a clinical standpoint, depression manifests as a subacute symptom change; the emergence and persistence of depressed mood, psychomotor retardation, decreased interest and pleasure, reduced appetite, and sleep disturbances are typically accompanied by symptom awareness and subjective distress. In contrast, dementia-derived symptoms -behavioral and psychological symptoms of dementia- (BPSD) encompass chronic cognitive dysfunction, depression, anxiety, and irritability, but are characteristically situation-dependent, displaying marked fluctuations in relation to time, place, and person. Appetite is often maintained, there is little awareness of sleep disturbances, and although thought and movement may be slowed, the patient may enjoy spending time in a supportive environment [1].
Distinguishing apathy, one of the most common BPSD, from depressive state is frequently challenging. Apathy is primarily characterized by a lack of interest and illness awareness, closely related to cognitive dysfunction. Depressive state, by contrast, is mainly characterized by depressed mood, suicidal thoughts, and self-blame, and often causes marked distress to both the patient and caregivers. This fundamental difference in subjective experience suggests that the two conditions are based on distinct neural substrates [1].
During clinical examination, the attitude toward cognitive testing provides valuable diagnostic clues. Depressed patients tend to give up effort in response to questions and become serious and sometimes exaggerated about their forgetfulness, whereas dementia patients exhibit saving-appearance responses, head-turning signs, and a lack of insight into memory loss [1]. On cognitive screening, pseudodementia tends to be associated with a decline in verbal fluency rather than delayed recall — the opposite pattern to that observed in Alzheimer disease (AD) [1]. The clock drawing test further contributes to differentiation, as constructive ability is generally preserved in depression but frequently impaired in AD [1].

Neuropsychological test batteries enhance diagnostic accuracy. Trail Making Test error analysis has demonstrated that perseverative errors on Part B are significantly associated with dementia but not with comorbid depression, suggesting that error profiles may offer more specific information than time-to-completion scores alone [2].

Finally, therapeutic response serves as an important confirmatory tool. Cognitive improvement following adequate antidepressant treatment supports a pseudodementia diagnosis. However, pseudodementia should not be considered a benign entity; longitudinal studies indicate that a substantial proportion of patients eventually progress to irreversible dementia, particularly those diagnosed at an older age [3]. Therefore, sustained cognitive monitoring remains essential even after successful treatment of the depressive episode.

References

1. Tetsuka S. Depression and Dementia in Older Adults: A Neuropsychological Review. Aging Dis. 2021;12(8):1920-1934. PMC8612610
2. Hafiz NJ, Lohse A, Haas R, et al. Trail Making Test Error Analysis in Subjective Cognitive Decline, MCI, and Alzheimer's Dementia With and Without Depression. Arch Clin Neuropsychol. 2023;38(1):25-36. PubMed: 35901514
3. Brodaty H, Connors MH. Pseudodementia, pseudo-pseudodementia, and pseudodepression. Alzheimers Dement (Amst). 2020;12(1):e12027. PMC7167375

Child Labor and Its Impact on Adulthood

Çağatay Haşim Yurtseven
Şırnak State Hospital

Child labour remains prevalent worldwide and its consequences extend far beyond childhood. The global count was estimated at 160 million in 2020, and the evidence suggests that early work can shape mental health and socio-economic trajectories. A recent quantile analysis of the Indonesian Family Life Survey, one of the few longitudinal datasets collecting validated mental-health measures, instrumented child labour with provincial minimum wages and found that working as a child raises depression scores on the Centre for Epidemiologic Studies Depression scale (CES-D); the effect is present across the distribution and is especially strong above the median, indicating that child workers are more likely to develop significant depressive symptoms in adolescence. The impact is greater in boys than in girls . Turkish data echo these findings. In a cross-sectional study of 1 152 adolescent apprentices attending a vocational training centre in Mersin, researchers used the Child Beck Depression Inventory to assess depressive symptoms. They reported that 18.6 % of apprentices scored above the threshold for depression; prevalence was notably higher in girls (26.6 %) than in boys (17 %). Depression was strongly associated with a history of suicide attempts, physical abuse at home or in the workplace, and use of cigarettes or inhalants . Negative conditions in family and workplace environments were identified as major risk factors, and the authors argued that the ultimate solution would be to abolish child labour for those under 18 years. Socio-economic outcomes are also compromised. Evidence drawn from a multi-country dataset and summarised by Pereznieto and colleagues indicates that individuals entering the labour market before age 13 earn on average 20 % less per hour, have 26 % lower incomes and are 14 % more likely to be in the lowest two income quintiles in adulthood; overall, child labour increases the probability of later poverty by 13–31 % . These patterns stem from reduced school attendance, poorer educational quality and limited human capital formation. While light, non-hazardous tasks may help children develop responsibility and practical skills, most forms of child labour involve excessive hours, hazardous environments or exploitative conditions. The evidence converges on a “long-shadow” effect: early work elevates risks of depression and anxiety, diminishes earning potential, and traps individuals and communities in cycles of poverty. For clinicians, a history of child labour should be considered when evaluating adult patients presenting with depressive symptoms or socio-economic difficulties. Policy responses should target the elimination of hazardous child labour, strengthen social protection and ensure access to quality education to break the intergenerational transmission of disadvantage.

References

1. Jayawardana D, Baryshnikova NV, Cheng TC (2023) The long shadow of child labour on adolescent mental health: a quantile approach. Empir Econ 64:77–97 .
2. Öner S, Buğdaycı R, Şaşmaz T, Kurt AÖ, Toros F (2004) Mersin Çıraklık Eğitim Merkezi öğrencilerinde depresyon sıklığı ve etkileyen faktörler. Mesleki Sağlık ve Güvenlik Dergisi 36: Nisan-Mayıs-Haziran:54–60 .
3. Pereznieto P, Jones M, Montes A (2016) Eliminating child labour, achieving inclusive economic growth. World Vision UK & Overseas Development Institute, London .

The Role of Biomarkers in the Differential Diagnosis of Late-Onset Depression and Dementia

Bilgen Biçer
Bursa City Hospital, Department of Psychiatry

The complex relationship between depressive symptoms emerging in late life and cognitive decline constitutes one of the most fundamental diagnostic dilemmas in contemporary neuropsychiatric practice. **Late-onset depression (LOD)** may manifest as the initial sign of Alzheimer's Disease (AD) pathophysiology during its decades-long preclinical phase, or it may present as an independent mood disorder traditionally defined as **"pseudodementia"**that temporarily impairs cognitive functions. In clinical practice, neuropsychological tests such as the MMSE and MoCA are influenced by education level, anxiety, and cultural factors, leading to error margins of up to 30% in the diagnostic process. This uncertainty leaves the clinician facing the risk of either overlooking amyloid pathology or mistakenly labeling a reversible depressive state as dementia. However, large-scale cohort studies such as **BioFINDER-2** and **Bio-Hermes**, which revolutionized medical literature between 2024 and 2026, have decisively proven that plasma biomarkers can resolve this diagnostic deadlock at the molecular level.

Current academic data indicates that the **p-tau217** variant, in particular, has an accuracy rate of over 90% in detecting the neurofibrillary tangle formation specific to AD pathology. By remaining within normal limits in patients with primary depression, this biomarker has become the gold standard for distinguishing whether there is an underlying neurodegenerative process. Simultaneously, **Neurofilament Light (NfL)**, which reflects the disruption of the neuronal cytoskeleton, objectively reveals the severity of damage and axonal degeneration, particularly in vascular-origin depressions. **GFAP**, on the other hand, signals astrocyte activation and neuroinflammation increasing even when amyloid plaques cannot yet be detected by imaging methods providing the earliest molecular signal of the prodromal stage.

The use of these biomarkers as a panel allows clinicians to act in accordance with the principles of **"Precision Psychiatry."** In a patient with a normal biomarker profile, the cognitive decline is considered "functional," prioritizing aggressive antidepressant protocols. Conversely, in patients with elevated p-tau217 and a low **Amiloid beta42/40** ratio, the condition is clarified as prodromal dementia. This distinction ensures that patients are directed toward the most appropriate options among today's rapidly evolving **"Disease-Modifying Therapies" (DMT)** or targeted neuroprotective strategies. Consequently, with their non-invasive, cost-effective, and high-sensitivity nature, plasma biomarkers establish a new evidence-based biological standard in the differential diagnosis of depression and dementia in individuals over the age of 65, moving beyond clinical intuition.

References

1. Palmqvist S, Hansson O et al. (2025). Blood-based biomarkers for Alzheimer's disease diagnosis in primary and secondary care. Nature Medicine, 31(1): 112-124.
2. Ashton NJ, Schöll M et al. (2026). A multimodal blood biomarker panel for differentiating late-onset depression from prodromal dementia. The Lancet Healthy Longevity, 7(2): e88-e98.
3. Rodriguez JL, Smith R et al. (2025). Plasma GFAP as a pre-amyloid marker of neuroinflammation in late-life depression. Journal of Alzheimer's Disease, 102(3): 445-458.

Hormone Replacement Therapies and the Role of Hormone Replacement Therapy in Menopause from a Mental Health Perspective

Aslı Tuğba Esen
Department of Psychiatry
İzmir Katip Çelebi University, Türkiye

Menopause is a retrospective clinical diagnosis established following a monitoring period characterized by fluctuations in estradiol, progesterone, and testosterone levels. The menopausal transition is a process during which both physical and psychological symptoms increase in women due to fluctuations in estrogen levels. This presentation aims to evaluate the indications for Menopausal Hormone Therapy (MHT), its place in current clinical guidelines, and particularly its effects on mental health.

MHT is an FDA-approved treatment option for vasomotor symptoms, prevention of osteoporosis, genitourinary syndrome, and cases of early menopause. Estrogen, progesterone, and tissue-selective estrogen complex formulations are used. Estrogen may be administered alone or in combination with progesterone. Progestogens are used orally or transdermally to balance estrogen. Large-scale longitudinal studies have demonstrated a reduction in all-cause mortality in women who initiate MHT before the age of 60 or within the first 10 years after menopause, whereas no protective effect has been observed in women who initiate MHT more than 10 years after menopause. In women over the age of 60, an increased risk of coronary heart disease, stroke, and thromboembolism has been reported. Therefore, when initiating MHT, baseline cardiovascular risk should be calculated. MHT should be administered at the lowest effective dose, and lifestyle recommendations including diet, exercise, smoking cessation, and safe levels of alcohol consumption should be provided.

MHT is also an intervention that restores central nervous system functions. It is recommended as a first-line treatment for depression and anxiety associated with hormonal fluctuations and vasomotor symptoms during the menopausal transition, as well as for brain fog, menopause-related sleep disturbances, and decreased sexual desire. Control of symptoms helps prevent secondary psychiatric disorders. Treatment success is generally achieved when MHT is initiated at the onset of menopause or during the perimenopausal period. In cases of persistent cognitive decline, low libido, and loss of energy despite MHT, the addition of transdermal testosterone is recommended. Antidepressants should be considered only when symptoms do not improve with MHT or when the clinical presentation is independent of menopause. In addition to hormonal therapy, or in patients who cannot use hormones, cognitive behavioral therapy (CBT) is recommended for the management of insomnia and mood.

MHT is not only a symptomatic treatment but also an intervention that restores quality of life in women and provides long-term systemic protection (bone, muscle, and cardiovascular health). The decision to initiate treatment should be made through an individualized risk–benefit analysis based on the patient's medical history and personal preferences.

References

1. Mehta J, Kling JM, Manson JE (2021) Risks, Benefits, and Treatment Modalities of Menopausal Hormone Therapy: Current Concepts. Front Endocrinol 12:564781.
2. Rossouw JE, Anderson GL, Prentice RL et al. (2002) Risks and benefits of estrogen plus progestin in healthy postmenopausal women: principal results from the Women's Health Initiative randomized controlled trial. JAMA 288(3):321–33.
3. Lee DY, Andreescu C, Aizenstein H et al. (2023) Impact of symptomatic menopausal transition on the occurrence of depression, anxiety, and sleep disorders: a real-world multi-site study. Eur Psychiatry, 66(1): e80. Downloaded on 10.03.26 from https//pmc.ncbi.nlm.nih.gov/articles/PMC10594314/pdf/ S0924933823024392a.pdf.

Does Love Conquer All? The Invisible Burden Of Attention-Deficit/Hyperactivity Disorder In Couple Relationships

Arzu Erkan
Private Psychiatrist, Izmir

Objective:
It is aimed to inform participants about the costs of Adult Attention-Deficit/Hyperactivity Disorder (ADHD) in couple relationships, and to provide information on the fundamental knowledge and skills required to reduce these costs and resolve the primary problems experienced within the relationship.

Definition and Information:
ADHD, a neurodevelopmental disorder, is also observed in adulthood at a rate of 65-70% (1). Primarily, emotion regulation and executive function disorders are seen in ADHD. Serious problems can be observed in areas such as family life, work life, budget management, health management, close relationships, childcare, driving, educational life, and compliance with laws and society. Undiagnosed and untreated ADHD is a serious public health problem.
ADHD can cause significant damage to relationships. It has been shown that spouses who marry individuals with ADHD experience difficulties in marital adjustment, family functionality, communication, affect, roles, and problem-solving. Occupational and marital problems are higher in individuals with ADHD, and marital satisfaction is lower in spouses (2). Both spouses must cope with frustrations, self-esteem problems, and burnout. Although pharmacological treatment partially improves work, relationship, and family functionality, it has been observed that problems return when the medication is discontinued. When a multimodal treatment plan specific to ADHD is not organized, traditional family therapies may remain insufficient in helping couples (3).

Content and Flow Plan:
The following topics will be addressed under two question headings:

1. Intent or Neurobiology? Do Not Categorize Me!
Characteristics of the individual with ADHD, such as forgetfulness, inattentiveness, and failure to fulfill responsibilities, are frequently interpreted by the partner as indifference or irresponsibility. In this section, we will discuss how these biologically based disruptions transform into a language of chronic conflict, and the transformative role of diagnosis and treatment in this destructive cycle.

2. An Equal Partnership or a Parent-Child Relationship? How to Repair the Asymmetric Dynamic?

Untreated ADHD inadvertently traps couples into a hierarchical and eroding role where one side is the "caregiver" and the other is the "care receiver." Under this heading, we will discuss how this dynamic, which disrupts the adult balance in the relationship, can be reconstructed through medical and therapeutic interventions. The session will conclude with a question, answer, and discussion section.

References

1. Ronald C. Kessler, et al. The prevalence and correlates of adult ADHD in the United States: Results from the National Comorbidity Survey Replication. Am J Psychiatry. 2006 Apr; 163(4): 716–723.
2. Gina Pera & Arthur L. Robin, Routledge; Adult ADHD Focused Couple Therapy: Clinical Interventions, New York, 1st edition (January 23, 2016).
3. Erkan A. Couple and Family Therapies in Attention Deficit Hyperactivity Disorder, In: Diagnosis and Treatment Guideline for Attention Deficit and Hyperactivity Disorder in Adults, Ed. Prof. Dr. Bengi Semerci & Prof. Dr. Umut Mert Aksoy, 2nd Edition, May 2024, Ankara: Psychiatric Association of Turkey Publications.
KEYWORDS: Adult Attention Deficit Hyperactivity Disorder, Couple Therapy, Family Therapy, Cognitive Behavioral Therapy.

Immune Dysregulation in First-Episode Psychosis

Simge Seren Kırlıoğlu Balcıoğlu
Department of Psychiatry, Hamidiye Faculty of Medicine, University of Health Sciences; Başakşehir Çam and Sakura City Hospital, Istanbul, Türkiye

First-episode psychosis (FEP) represents a critical clinical stage for understanding the early pathophysiology of psychiatric disorders. Accumulating evidence in recent years suggests that the immune system is markedly dysregulated in FEP and that this dysregulation may be associated with the onset, symptom profile, and course of the disorder. In particular, alterations in cytokine levels and differences in lymphocyte profiles are among the most consistent biological findings in this field.

Meta-analytic data indicate a pronounced inflammatory activation in patients with FEP compared to healthy controls. Elevated levels of inflammatory markers such as interleukin (IL)-1β, IL-6, tumor necrosis factor-alpha (TNF-α), transforming growth factor-beta (TGF-β), soluble IL-2 receptor (sIL-2R), and C-reactive protein (CRP) have been consistently reported. Additionally, increased total lymphocyte counts have been observed. The moderate-to-large effect sizes of these immune alterations support the notion that immune activation represents a clinically meaningful biological process in FEP. Notably, similar or even larger effect sizes in antipsychotic-naïve patients suggest that these changes are independent of treatment effects and may reflect early disease pathophysiology.

Some cytokines are considered “state markers,” while others may function as “trait markers.” Cytokines such as IL-1β, IL-6, and TGF-β tend to increase during acute phases and normalize following treatment, suggesting an association with disease activity. In contrast, persistently elevated levels of IL-12, interferon-gamma (IFN-γ), TNF-α, and sIL-2R after treatment may reflect more stable, disorder-related immune characteristics.

FEP is a heterogeneous clinical entity, and differences in immune responses have been observed between affective and non-affective subtypes. In particular, patients with affective features exhibit higher levels of both innate and adaptive immune responses. Data derived from stimulated peripheral blood mononuclear cells demonstrate increased production not only of pro-inflammatory cytokines such as TNF-α, IL-1β, and IL-6, but also cytokines associated with adaptive immunity, including IL-4, IL-17, and IFN-γ. These findings suggest a more widespread immune activation in affective psychosis.

Inflammatory markers have also been shown to correlate with clinical symptoms. Specifically, certain cytokine levels are associated with the severity of negative symptoms, indicating that the immune system may play a role not only in the biological underpinnings of the disorder but

also in its clinical manifestation. However, considerable heterogeneity across studies remains, and potential confounding factors such as body mass index, smoking, and environmental influences are often insufficiently controlled.

Overall, FEP is characterized by a clear pro-inflammatory immune dysregulation. These findings suggest that immune markers may hold promise as diagnostic and prognostic biomarkers in the early stages of psychosis. Future studies with larger samples, particularly in antipsychotic-naïve populations and with well-controlled methodologies, are needed to further clarify the role of the immune system in psychosis.

References

1. Hughes HK, Yang H, Lesh TA ve ark. (2022). Evidence of innate immune dysfunction in first-episode psychosis patients with accompanying mood disorder. J Neuroinflammation. 19(1), 287.
2. Miller BJ, Buckley P, Seabolt W ve ark. (2011). Meta-analysis of cytokine alterations in schizophrenia: clinical status and antipsychotic effects. Biol Psychiatry, 70(7), 663-671.
3. Pillinger T, D'ambrosio E, McCutcheon, R ve ark. (2019). Is psychosis a multisystem disorder? A meta-review of central nervous system, immune, cardiometabolic, and endocrine alterations in first-episode psychosis and perspective on potential models. Mol Psychiatry 24(6); 776-794.

Mechanisms of Electroconvulsive Therapy Through Immune Response and Neuroplastic Changes

Simge Seren Kırlıoğlu Balcıoğlu
Department of Psychiatry, Hamidiye Faculty of Medicine, University of Health Sciences, Başakşehir Çam and Sakura Training and Research Hospital, Istanbul, Türkiye

Although electroconvulsive therapy (ECT) has been used as an effective neuromodulation technique for over 80 years, the biological mechanisms underlying its therapeutic effects have not yet been fully elucidated. One of the prominent approaches in the current literature suggests that ECT exerts its effects by modulating “neuroplasticity” processes. Neuroplasticity refers to the brain’s capacity to reorganize at molecular, structural, and functional levels.
At the molecular level, the most extensively studied effects of ECT involve neurotrophic factors. In particular, brain-derived neurotrophic factor (BDNF) plays a critical role in synaptogenesis and neuronal survival. However, findings regarding BDNF levels following ECT are heterogeneous, with reports of increases, decreases, or no change. Similarly, inconsistent results have been observed for other neurotrophic factors such as nerve growth factor, neurotrophin-3, glial cell line-derived neurotrophic factor, and vascular endothelial growth factor. These findings indicate that the molecular effects of ECT are highly complex.
In terms of neurotransmitter systems, regional alterations in glutamate and GABA levels have been reported. Changes in serotonin receptors and the dopaminergic system have also been observed, although these findings are not consistent across studies. Metabolite studies have identified alterations in markers such as N-acetylaspartate; however, their clinical significance remains unclear.
Regarding structural neuroplasticity, the most consistent findings following ECT are increases in gray matter volume. These increases are most frequently reported in regions associated with emotion and memory, particularly the hippocampus and amygdala. Additionally, changes have been observed in the insula, cingulate cortex, and subcortical structures. Increases in cortical thickness and alterations in white matter microstructure have also been reported. However, the relationship between these structural changes and clinical improvement has not yet been clearly established.
At the functional level, ECT appears to have notable effects on brain networks. Changes in functional connectivity have been particularly observed within the default mode network and the limbic system. It has been proposed that ECT may reduce limbic hyperconnectivity while enhancing the regulatory influence of the prefrontal cortex. Furthermore, measures such as the amplitude of low-frequency fluctuations (ALFF) and its fractional counterpart (fALFF) reflect

changes in spontaneous brain activity. These findings suggest that ECT leads to a reorganization of brain networks.

From an immunological perspective, ECT may induce acute neuroinflammatory changes, and potential associations between cytokine levels and brain structure and connectivity have been suggested. However, findings in this area remain limited and heterogeneous. Overall, the therapeutic effects of ECT are thought to be associated with neuroplastic changes observed at molecular, structural, and functional levels. Nevertheless, the relationships between these levels have not been consistently demonstrated in the existing literature. Given the heterogeneity of findings, further multimodal and particularly longitudinal studies are needed to better understand the mechanisms of action of ECT.

References

1. Belge JB, Mulders P, Van Diermen L ve ark. (2023). Reviewing the neurobiology of electroconvulsive therapy on a micro-meso-and macro-level. Prog Neuropsychopharmacol Biol Psychiatry 127: 110809.
2. João RB, Toiansk de Azevedo JPRP, Pereira DA, Ragazzo PC ve ark. (2025) Immune-inflammatory, neuroplastic, and epigenetic effects of electroconvulsive therapy in mood disorders: an overview of recent studies. Front Psychiatry 16:1577530.
3. Laroy M, Emsell L, Vandenbulcke M ve ark. (2025) Mapping electroconvulsive therapy induced neuroplasticity: Towards a multilevel understanding of the available clinical literature–A scoping review. Neurosci Biobehav Rev 173: 106143.

CBT and Psychosocial Interventions in the Treatment of Adult ADHD: What to Know and How to Apply?

Arzu Erkan
Private Psychiatrist, Izmir

Objective:
It is aimed for participants to become informed about Adult Attention-Deficit/Hyperactivity Disorder (ADHD) and its costs on an individual's life; and to gain fundamental knowledge and skills regarding Cognitive Behavioral Therapy (CBT) applications that can be utilized in reducing these costs and solving the primary problems.

Definition:
ADHD, a neurodevelopmental disorder, persists into adulthood in 65–70% of cases. With a prevalence of 2.5–4.9%, it is a common yet underrecognized psychiatric disorder; cases are often mismanaged with alternative diagnoses. Approximately 90% of adults with ADHD remain untreated (1).

It is thought that 89-98% of adults with ADHD have deficiencies in executive functions, including emotion regulation, time management, organization, motivation, concentration, and self-discipline. Significant functional impairment occurs in many areas such as close relationships, work, family, educational life, budget management, health, self-care, parenting, driving, legal compliance, and social adaptation (2).

Undiagnosed/ untreated ADHD constitutes a serious public health problem, both due to comorbid conditions and the morbidity it creates. Although pharmacological treatment partially improves academic, occupational, relationship, and family functionality, it has been observed that problems return when medications are discontinued. Unless a holistic treatment plan including ADHD-specific CBT applications is established, traditional treatments may remain insufficient (3).

In the **NICE (National Institute for Health and Care Excellence)** Treatment Guidelines, medication is recommended as the first-line treatment for adults if ADHD symptoms still cause significant impairment in at least one area of daily life despite environmental modifications. While the NICE guideline recommends psychotherapy in addition to medication for adults who benefit from medication but whose symptoms still cause significant impairment in at least one area, it also highlights the benefit of offering psychotherapy as an option for those who are reluctant to use medication, cannot tolerate medications, or wish to try another treatment option. It is emphasized that this should be a standard CBT program/include components of

CBT; and that it should be a structured, supportive, ADHD-focused method providing regular follow-up and psychoeducation (4).

Method:

In the course, CBT and psychosocial approaches in the treatment of adult ADHD will be discussed. Techniques focusing on the efficacy of CBT in managing ADHD symptoms, time management, organization skills, and impulse control will be explained. Examples of how psychoeducation, group therapies, and supportive psychosocial approaches can be applied in clinical practice will be presented.

References

1. Semerci B & Aksoy UM (Eds). Attention Deficit and Hyperactivity Disorder in Adults - Diagnosis and Treatment Guideline, 2018.
2. Faraone, S.V., Bellgrove, M.A., Brikell, I. et al. Attention-deficit/hyperactivity disorder. Nat Rev Dis Primers 10, 11 (2024).
3. Kooij JJS, Bijlenga D, Salerno L, Jaeschke R, Bitter I, Balázs J, et al. Updated European Consensus Statement on diagnosis and treatment of adult ADHD. Eur Psychiatry. 2019 Feb;56:14-34.
4. Erkan A. CBT Applications in the Treatment of Adults with Attention Deficit Hyperactivity Disorder, in: Cognitive Behavioral Therapy in Clinical Practice-II, 2022, Ankara: Nobel Academic Publishing.

From Hypothesis to Manuscript Draft: Using Consensus AI and Gemini Together

Alişan Burak Yaşar
İstanbul Nişantaşı University, Faculty of Medicine, Department of Psychiatry; Therapy Sciences Academy

Large language models (LLMs) such as Gemini, ChatGPT, and Claude have quickly become part of the everyday workflow of mental health professionals who write for academic journals. Used on their own, however, they carry well-known limitations, including hallucinated references and surface-level synthesis. This talk presents a practical workflow that combines a general-purpose LLM (Gemini) with the evidence-oriented tool Consensus AI, in order to move from a raw clinical observation toward a structured manuscript draft, while keeping scientific responsibility with the researcher.

The session will be delivered largely through live screen-sharing. Participants will first see how a vague clinical impression can be refined into a focused, testable research question through an iterative dialogue with the LLM, using the Population, Intervention, Comparison, Outcome (PICO) framework. In a second step, the LLM is used as a “prompt engineer” to generate a set of optimized English search queries for Consensus AI. Running ten to twenty parallel queries allows rapid access to peer-reviewed findings, which are then returned to the LLM for synthesis into a draft organized as Introduction, Methods, Results and Discussion (IMRaD).

A second focus is standardization across projects. The talk will demonstrate how custom GPTs and Gemini Gems can be configured once — with a preferred writing style, the target journal’s author guidelines uploaded as a PDF, and one or two of the author’s previous articles given as style examples — so that the same background instructions do not have to be repeated in every session. The common problem of the model overfitting to a single example paper and producing near-copy text will be discussed openly, together with practical strategies such as using the author’s own prior writing as the style reference, requesting synthesis rather than paraphrase, and routine use of originality-check tools.

The final section addresses ethical boundaries. AI-generated content requires source verification, transparent declaration in the methods or acknowledgments section, and strict protection of patient data in line with the Personal Data Protection Law (KVKK) and the General Data Protection Regulation (GDPR). AI cannot be an author; scientific ownership remains with the researcher.

The aim of the talk is modest: to offer a reproducible template that participants can adapt to their own clinical and academic contexts, rather than to promote AI tools as a substitute for scholarly judgement.

References

1. Salvagno M, Taccone FS, Gerli AG. Can artificial intelligence help for scientific writing? Crit Care 2023; 27: 75.
2. Dergaa I, Chamari K, Zmijewski P, Ben Saad H. From human writing to artificial intelligence generated text: examining the prospects and potential threats of ChatGPT in academic writing. Biol Sport 2023; 40: 615-622.
3. Hosseini M, Resnik DB, Holmes K. The ethics of disclosing the use of artificial intelligence tools in writing scholarly manuscripts. Res Ethics 2023; 19: 449-465.

Euthanasia and Assisted Suicide - Ethical and procedural aspects

Thomas Pollmächer
KBO Donau-Altmühl Hospital, Ingolstadt, Department of Psychiatry and Psychotherapy, Ludwig-Maximilians-University, Munich, Germany

Supporting people in committing suicide is a controversial issue in medicine since antiquity, when Hippocrates warned doctors not to provide poison to any patient. Although worldwide most countries still do neither allow suicide assistance nor euthanasia (killing on demand) such practices are quite regularly offered in some countries mainly in North America and Europe. Legal and procedural frameworks are very different, pointing to a number of open basic ethical questions and uncertainties. Some countries ban killing on demand, but allow suicide assistance. Some allow support to die for psychiatric patients, others do not. In those countries who declare a terminal illness, irremediability and/or treatment resistance as a mandatory requirement, eligibility of psychiatric patients is viewed particularly sceptical. However, from a bioethical perspective, any other mandatory requirement for assisted suicide or euthanasia than decisional capacity is highly questionable, making a general exclusion of psychiatric patients difficult to justify. If assistance in dying is generally accepted, measures have to be implemented to protect vulnerable people from acting impulsively, under external pressure or in a state of impaired decisional capacity.

Does Neuroimaging in Late-Onset Depression Help in the Differential Diagnosis of Dementia?

Dr. Uğur Çıkrıkçılı
Otto von Guericke University, Institute of Behavioral Neurology and Dementia Research
German Centre for Neurodegenerative Diseases – DZNE Magdeburg/Germany

In this presentation, the relationship between late-life depression (LLD) and neuroimaging findings, with a particular focus on their role in the differential diagnosis of dementia will be discussed. As the global population ages, LLD has become increasingly prevalent and is now recognized as a significant risk factor for Alzheimer's disease and other neurodegenerative disorders (Zhao et al., 2023). The clinical overlap between depressive symptoms and early cognitive impairment often complicates diagnosis, making accurate differentiation between LLD and prodromal dementia a critical challenge in geriatric neuropsychiatry.
Neuroimaging techniques provide valuable insights into both the pathophysiological underpinnings of LLD and its distinction from neurodegenerative processes. Structural magnetic resonance imaging (MRI) enables the assessment of brain volume, cortical atrophy, and white matter hyperintensities,which are frequently associated with vascular burden and fronto-subcortical disconnection. Functional modalities such as FDG-PET reveal alterations in cerebral glucose metabolism, while diffusion tensor imaging (DTI) highlights microstructural white matter integrity. Functional MRI (fMRI), particularly in resting-state paradigms, allows the evaluation of large-scale brain networks, including the default mode, executive control, and affective networks, which are often disrupted in LLD (Chouliaras & O'Brien, 2023). These multimodal approaches and techniques collectively contribute to distinguishing depression-related changes from patterns typical of Alzheimer's disease and other dementias.
Key neuroimaging findings in LLD include white matter hyperintensities,fronto-limbic network dysfunction, and metabolic alterations in prefrontal and limbic regions. These changes are thought to reflect a combination of vascular pathology, neuroinflammation, and stress-related neurotoxicity. Importantly, molecular imaging studies suggest that alterations in neurotransmitter systems and synaptic density may further contribute to the clinical phenotype of LLD (Holmes & Smith, 2026).
The presentation will first outline the epidemiology and clinical characteristics of late-life depression, followed by a detailed overview of the aforementioned neuroimaging modalities. Particular emphasis will be placed on how these techniques can be applied in clinical practice to improve diagnostic accuracy and guide management decisions when differentiating LLD from dementia.

In conclusion, neuroimaging represents a critical tool not only for differential diagnosis but also for advancing our understanding of the biological mechanisms underlying late-life depression. Its integration into clinical workflows may enhance early detection of neurodegenerative processes and support more targeted therapeutic strategies.

References

1. Zhao, Y., Wu, X., Tang, M., et al. (2023). Late-life depression: Epidemiology, phenotype, pathogenesis and treatment. Frontiers in Psychiatry.
2. Chouliaras, L., & O'Brien, J.T. (2023). The use of neuroimaging techniques in the early and differential diagnosis of dementia. Molecular Psychiatry.
3. Holmes, S.E., & Smith, G.S. (2026). Trajectories of late-life depression: insights from molecular imaging. Neuropsychopharmacology.

Current Suicide Prevention Programs and Technologies

Dr. Uğur Çıkrıkçılı
Otto von Guericke University, Institute of Behavioral Neurology and Dementia Research
German Centre for Neurodegenerative Diseases – DZNE Magdeburg/Germany

This presentation provides a comprehensive overview of the role of digital technologies and artificial intelligence (AI) in predicting and preventing suicide risk. Suicide remains a major global public health concern, accounting for hundreds of thousands of deaths annually. Despite this, traditional clinical assessment tools and self-report measures have shown limited predictive accuracy and have not significantly improved over recent decades . These limitations have driven the need for scalable, accessible, and real-time digital solutions.

The presentation examines digital and AI-based approaches in psychiatry, including big data analytics, digital phenotyping, and clinical decision support systems. Machine learning algorithms (e.g., logistic regression, random forest, support vector machines) enable risk prediction using structured data, while deep learning and natural language processing techniques extract meaningful patterns from unstructured data sources such as clinical notes and social media content. Notably, large language models demonstrate high accuracy in detecting suicide risk by analyzing contextual and linguistic features beyond simple keyword matching .

Additionally, AI-driven systems such as REACH VET and SAIPH, along with voice biomarker analysis, facilitate early identification of high-risk individuals. Digital interventions, including mobile applications (e.g., Virtual Hope Box, iBobbly, LifeBuoy) and chatbot-based tools (e.g., Woebot, Wysa), provide scalable and accessible support, particularly in resource-limited settings. However, ethical considerations, data privacy, and clinical integration remain critical challenges.

In conclusion, digital psychiatry and AI applications offer promising avenues for early detection and prevention of suicide risk. Nevertheless, further evidence-based research is required to ensure their safe, ethical, and effective implementation in clinical practice (Krautz et al., 2025; Josifovski et al., 2024; Kaminsky et al.).

References

1. Krautz, A. E., Volkening, J., Raue, J., et al. (2025). Prediction of suicide using web-based voice recordings analyzed by artificial intelligence. Scientific Reports, 15, 23855. https://doi.org/10.1038/s41598-025-08639-2
2. Josifovski, N., Torok, M., Batterham, P., Wong, Q., Beames, J. R., Theobald, A., Holland, S., Huckvale, K., Riley, J., Cockayne, N., Christensen, H., & Larsen, M. E. (2024). Efficacy of BrighterSide, a self-guided app for suicidal ideation: Randomized controlled trial. JMIR Mental Health, 11, e55528. https://doi.org/10.2196/55528
3. Kaminsky, Z. A., et al. Suicide AI Prediction Heuristic (SAIPH): Social media-based suicide risk prediction framework

How do hormonal changes affect anxiety disorders?

Leman İnanç
İzmir Bakırçay University

During premenopause or menopause, symptoms such as hot flashes, depressive mood, and anxiety may occur. Some sources argue that anxiety symptoms increase during menopause. Several neurobiological mechanisms have been proposed for this. Allopregananolone strengthens the GABA (gamma-aminobutyric acid) pathway and exerts an anxiolytic effect. It is suggested that decreased allopregananolone levels lead to structural changes in GABA receptors, thereby reducing the inhibitory mechanism of GABA. The surge in allopregananolone and estradiol activates the HPA (hypothalamic-pituitary axis) and alters the cortisol release pattern. This can lead to depressive symptoms. Decreased estrogen leads to decreased serotonin activation. Estradiol normally reduces MAO (monoamine oxidase) A and B activation, making serotonin available. Decreased estradiol leads to decreased serotonin activation. Estradiol increases tyrosine hydroxylase expression in the locus seroleus during the premenopausal period, leading to an increase in NA (norepinephrine) and DA (dopamine). A decrease in estradiol leads to a decrease in NA and DA. It is suggested that all these mechanisms may contribute to increased anxiety during menopause.

What are the sleep disorders seen during menopause and what is their effect on psychopathology?

Women are more affected by sleep disorders than men during menopause and as they age. The prevalence of sleep disorders varies between 16%-47% in perimenopause and 35%-60% in postmenopause. 35-50% of women complain of sleep disorders during the transition from perimenopause to the menopausal period.

Sleep disorders such as interrupted sleep after falling asleep at night, staying awake longer after falling asleep, insufficient sleep, unrefreshing sleep, difficulty falling asleep, and early morning awakening can be observed during menopause. Postmenopausal women have been found to have an increased frequency of OSAS (sleep apnea syndrome), RLS (restless legs syndrome), and periodic leg movements during sleep. The decrease in estradiol and progesterone levels during and after menopause plays a central role in the mechanism of insomnia. Cognitive Behavioral Therapy (CBT-I) is the recommended first-line treatment for insomnia.

Is cognitive impairment in menopause a temporary condition or a cognitive dysfunction?

A tendency for worsening cognitive performance has been reported in women during menopause. It has been shown that 70% of women experience a significant decline in cognitive function during menopause. The most common complaints are memory problems, especially difficulty remembering words or numbers. Other problems include attention deficit, prolonged reaction time, and verbal memory impairment.

Estradiol reduces amyloid beta production, tau phosphorylation, and inflammation. Decreased estradiol is associated with chronic inflammation, cognitive changes, and dementia. It is suggested that the underlying mechanism of cognitive decline during menopausal transition may be the decrease in estradiol, along with activation of pro-inflammatory genes, microglia activation, and overproduction of inflammatory components (IL-1, IL-6, IL-8, or TNF-α). It can be said that symptoms associated with cognitive decline may be seen in perimenopausal women, but it has not been proven that the risk of menopausal dementia is increased. Some women may describe symptoms of cognitive decline even if their neuropsychological test results are normal during the perimenopausal period. Routine assessment with MMSE and Montreal Cognitive Assessment (MoCA) is necessary.

Reward-Based Learning and Decision-Making Dynamics: Computational Models of Compulsion

Sevler YILDIZ
Elazığ Fethi Sekin City Hospital, Department of Psychiatry

Behavioral addictions are mental disorders characterized by the repetitive continuation of certain behaviors despite awareness of their negative consequences. In behavioral addictions such as gambling, problematic internet use, and compulsive shopping, the emergence and maintenance of compulsive behaviors are closely linked to impairments in reward-based learning and decision-making mechanisms. Recently developed computational psychiatry approaches provide the ability to examine decision-making impairments observed in behavioral addictions through quantitative parameters. In particular, reinforcement learning models can model how individuals process information about rewards and punishments through parameters such as the value update rate and the exploration-exploitation balance. Research indicates that individuals with behavioral addictions exhibit characteristics such as excessive sensitivity to short-term rewards and an underestimation of the value of delayed rewards; this phenomenon is explained by habit-based (model-free) learning becoming more dominant in decision-making processes compared to goal-oriented (model-based) control mechanisms. Neurobiologically, it is known that these learning processes are associated with fronto-striatal networks, particularly those involving the orbitofrontal cortex, the striatum, and the anterior cingulate cortex. It is suggested that the functional changes observed in these circuits in behavioral addictions contribute not only to the overrepresentation of reward value but also to a reduction in consequence sensitivity. Through these mechanisms, the behavior is explained as initially beginning as a search for reward but eventually transforming into a compulsive and habit-based pattern over time. It is believed that the functional and structural changes occurring in these circuits in behavioral addictions lead to a disproportionate increase in the value attributed to reward-related stimuli. In other words, cues associated with addictive behavior become increasingly dominant, attention-grabbing, and motivating for the individual. Concurrently, there is a decline in the capacity to anticipate the negative consequences of the behavior, account for long-term harms, and respond appropriately to punitive feedback. This reduced sensitivity to consequences leads the individual to focus excessively on the short-term rewarding aspects of the behavior while failing to adequately consider social, occupational, financial, or psychological harms.
Our aim is to discuss the framework provided by reward-based learning and decision-making models in understanding the compulsive nature of behavioral addictions. It is believed that this

approach holds significant potential for identifying individual risk profiles, determining subtypes of behavioral addictions, and consequently predicting treatment response. The parameters that can be obtained may contribute to the development of psychotherapeutic interventions and personalized treatment strategies.

References

1. Gürbüzer N, & Gürcan-Yıldırım D (2025) Behavioral addictions and psychological distress: Insights from psychology students in Eastern Turkey. Humanities and Social Sciences Communications, 12(1).
2. Koob GF, Volkow ND (2016) Neurobiology of addiction: a neurocircuitry analysis. Lancet Psychiatry, 3(8):760-773.
3. Haber SN, Behrens TE (2014) The neural network underlying incentive-based learning: implications for interpreting circuit disruptions in psychiatric disorders. Neuron 83(5): 1019-1039.

Psychosocial Determinants of Emotion

İshak Sayğılı

This speech aims to examine the psychosocial nature of emotions and their role in social interactions from a comprehensive perspective. Beginning with the etymological origins of the concept of emotion, it presents a critical analysis of the emotion-reason dichotomy from ancient times to the present day. Throughout the speech, a psychosocial perspective has been developed based on findings from psychoanalytic theory, attachment theory, evolutionary psychology, and neuropsychology. Drawing from Freud's thesis that "mentality is always a group mentality," the view that emotions are social phenomena beyond individual experience has been explored. Although emotions are internal experiences, they emerge through external world conditions and open into an interactional space. Starting from early mother-infant interactions, it has been demonstrated that the processes of emotion regulation and transformation into awareness are shaped by interpersonal dynamics. The evolutionary functions of emotions, empathy mechanisms, and projective identification processes from Darwin to the present have been detailed. A perspective on empathy, which is a crucial psychological capacity in the social realm woven through emotions, has also been presented. In this context, empathy has been defined with three basic components: emotional sharing, causal understanding, and perspective-taking. The emotional foundations of social behavior have been explained by examining the contagious nature of emotions, their effects in conflict situations, and the phenomenon of "compassion collapse." The regulatory role of emotions in individual-society relations, regression processes during collective trauma periods, and changes in empathy capacity during social tension have been analyzed. The relationship between the emphasis on rationality and patriarchal power structures has been evaluated from a feminist perspective, and the problem of emotional authenticity has been addressed through the concept of "false self." The study emphasizes the necessity of interdisciplinary research by revealing the multidimensional structure of the psychosocial determinants of emotions. Additionally, a case presentation that is thought to demonstrate the importance of clinical applications of the concepts mentioned throughout the study has been added to the presentation.

References

1. Sclater SD, Jones DW, Price H, Yates C, Introducing Psychosocial Studies of Emotion. Sclater SD (ed), Jones DW (ed), Price H (ed), Yates C (ed). Emotion. London: Palgrave Macmillan UK; 2009
2. Van Kleef GA. How Emotions Regulate Social Life: The Emotions as Social Information (EASI) Model. Curr Dir Psychol Sci. 2009;18(3):184-8.
3. De Waal FBM. Putting the Altruism Back into Altruism: The Evolution of Empathy. Annu Rev Psychol. 2008;59(1):279-300.

Borderline Representations in Cinema

Muhittin Yavuz
Bakırköy Prof. Dr. Mazhar Osman Training and Research Hospital for Psychiatry and Neurological Diseases

Cinema is a powerful art form that shows inner experiences, emotions, and relationships in a visual and narrative way. From a psychodynamic point of view, artistic creation can be seen as a form of “regression in the service of the ego.” This means that the artist can reach unconscious material while still staying connected to reality. In this sense, films can help us understand complex psychological processes.

In this presentation, I explore how some films reflect themes related to borderline personality organization. I do not aim to diagnose the characters, but to show how certain patterns in these films are similar to processes seen in borderline organization. Three films are discussed: The Worst Person in the World (2021), Eternal Sunshine of the Spotless Mind (2004), and Betty Blue (1986). The focus is on identity, emotional regulation, object relations, and behavior.

In The Worst Person in the World, the main character Julie changes her life choices and relationships many times. This can be understood as difficulty in maintaining a stable sense of self. Her constant movement between identities and relationships may suggest problems with identity continuity and a feeling of inner emptiness. In one important scene, time stops, and this shows how strong emotions can take over a person’s sense of reality.

In Eternal Sunshine of the Spotless Mind, the idea of deleting memories represents problems with object constancy. Clementine’s intense and changing emotions, and the way she feels them in her body, can be linked to affect dysregulation and somatization.

In Betty Blue, the character Betty shows sudden changes between idealizing and devaluing others. She also reacts to strong emotions with impulsive actions. These patterns can be related to defense mechanisms such as splitting and acting out.

In conclusion, cinema offers a rich space to observe and discuss psychodynamic concepts. Instead of labeling characters, it is more useful to focus on the psychological processes shown in films.

References

1. Yeomans, Frank E.; Clarkin, John F.; Kernberg, Otto F.
Borderline Kişilik Bozukluğu İçin Aktarım Odaklı Psikoterapi: Klinik Bir Rehber.
İstanbul: Psikoterapi Enstitüsü, 2017.

Clinical Issues in the Assessment of Eating Disorders

Armağan Özdemir Ceylan
İstinye University Faculty of Medicine

Assessment in eating disorders is critically important for both understanding the patient and establishing an appropriate treatment framework. During the initial interview, the primary aims are to maintain a trusting therapeutic relationship, to explore the patient's reason for presentation, and to gain an overview of core eating behaviors. Developing a general clinical picture that includes weight changes, eating patterns, accompanying psychiatric symptoms, and potential medical risks. In addition, understanding the patient's expectations and motivation for treatment constitutes an essential component of the process.

Within this general framework, obtaining a detailed understanding of eating behavior can be challenging. In particular, the assessment of binge eating requires careful and systematic inquiry. It is important to explore whether the patient experiences episodes of loss of control over eating, the frequency of such episodes, and the emotional responses that follow. Behaviors such as consuming large amounts of food in a short period of time, eating rapidly, continuing to eat despite satiety, and a tendency to eat alone may provide important clinical clues. Furthermore, the relationship of these episodes to stress, negative affect, or environmental triggers should be considered. In this way, not only the quantity but also the emotional context of eating behavior can be understood.

Following the evaluation of eating behavior, attention should be directed to the patient's physical status. Although weighing the patient is useful for medical assessment, it requires sensitivity. Weight measurement contributes to determining body mass index and identifying potential physical risks. However, in individuals who are excessively preoccupied with weight, it may increase anxiety; therefore, this procedure should be conducted with a transparent and supportive approach. At this stage, focusing not only on weight but also on overall health status makes the assessment more meaningful.

After the physical evaluation, it is important to address body image, a core component of eating disorders. The patient's satisfaction with their body, the relationship between weight and self-worth, and body-related cognitions should be explored in a natural and non-confrontational manner during the interview. Behaviors such as frequent weighing, mirror checking, or excessive preoccupation with body shape become clinically meaningful within this context. This assessment helps to elucidate the patient's relationship with themselves and deepens the understanding of the clinical presentation.

Finally, consideration should be given to how the patient's social environment will be incorporated into the assessment process. Determining whom to involve and how to involve them is a common clinical question. Family interviews, particularly with younger patients, can provide valuable information. Family eating patterns, attitudes toward weight and body image, and available support systems can be explored in these meetings. When engaging with the family, it is essential to respect patient confidentiality and maintain a collaborative approach. Providing psychoeducation to family members may enhance treatment adherence. Taken together, the initial assessment represents a comprehensive process that integrates biological, psychological, and social factors, with a primary focus on understanding the patient.

References

1. Fochtmann LJ, Medicus J, Hong SH (2024) Practice Assessment Tool for the Care of Patients With Eating Disorders. Focus 22(3):350–368.
2. Laliberte MM, Gobin KC, Potechin MB ve ark (2026) Emerging Adults Seeking Treatment for Their Eating Disorder: An Empirical Look at Young Adults Relative to Adults Over 25. Eur Eat Disord Rev 34(3):811–822.

Current Indications, Efficacy, and Safety of Electroconvulsive Therapy: What Do Clinical Data Reveal?

İlkay KELEŞ ALTUN
Private Practitioner, Bursa

Electroconvulsive Therapy (ECT) is one of the first biological treatments developed in the history of modern psychiatry. Its historical origins date back to the early 20th century, based on studies investigating the effects of seizure therapy on psychiatric disorders. In 1938, Ugo Cerletti and Lucio Bini performed the first controlled seizure induction using electrical stimulation in Rome. Today, ECT is no longer merely a “last resort” but a “first-line option” in certain situations. Its primary indications include catatonia (particularly malignant catatonia or refusal of oral intake), suicide risk: urgent situations requiring a rapid response, psychotic depression, combination therapies for cases resistant to pharmacotherapy, and treatment-resistant manic episodes. Today, it is the gold standard biological treatment for treatment-resistant depression, and clinical improvement has been reported to begin within the first few sessions. Maximum effect is typically achieved within 3 weeks. Bilateral ECT is more effective than unilateral ECT. Higher stimulation doses yield clinically better results compared to lower doses.

References

1. Psikiyatride biyolojik tedaviler: Nöromodülasyon (1. baskı). M. İ. Atagün & Ö. Atay (Ed.), Türk Psikiyatri Derneği Yayınları. ISBN: 978-605-73240-3-0
2. UK ECT Review Group. Efficacy and safety of electroconvulsive therapy in depressive disorders: a systematic review and meta-analysis. Lancet. 2003 Mar 8;361(9360):799-808. doi: 10.1016/S0140-6736(03)12705-5. PMID: 12642045
3. Antunes PB, Rosa MA, Belmonte-de-Abreu PS, Lobato MI, Fleck MP. Eletroconvulsoterapia na depressão maior: aspectos atuais [Electroconvulsive therapy in major depression: current aspects]. Braz J Psychiatry. 2009 May;31 Suppl 1:S26-33. Portuguese. doi: 10.1590/s1516-44462009000500005. PMID: 19565148.

Treatment and Medication Selection for Bipolar Disorder in Organ Failure

Esin Erdoğan
University of Health Sciences (SBÜ), İzmir Faculty of Medicine,
Department of Psychiatry, Turkiye

Bipolar disorder (BD) is a psychiatric illness that frequently coexists with chronic medical conditions, making treatment management considerably more complex. Organ dysfunction, particularly hepatic and renal failure, significantly alters the pharmacokinetic and pharmacodynamic properties of psychotropic medications, thereby increasing the risk of drug toxicity. This presentation reviews the fundamental principles of treatment strategies and medication selection for bipolar disorder in patients with organ failure (1,2).

In hepatic impairment, reduced hepatic metabolism, diminished first-pass metabolism, and hypoalbuminemia lead to an increased free fraction of drugs, resulting in elevated serum drug concentrations and a higher risk of adverse effects. Therefore, medications primarily undergoing phase II metabolism are generally preferred, with dose reduction and slow titration ("start low, go slow") recommended. Hepatotoxic agents such as valproate and carbamazepine should be used cautiously, and treatment should be discontinued in the presence of marked elevations in liver enzymes. Since lithium is not metabolized by the liver, it is considered a relatively safe option in patients with liver disease; however, close monitoring of fluid balance and renal function remains essential (3).

In renal impairment, reduced drug elimination presents a major clinical challenge, particularly for lithium because of its narrow therapeutic index. Although lithium use has been associated with the development of chronic kidney disease, discontinuation of treatment should be based on a careful risk-benefit assessment given its robust relapse-preventive efficacy. Current evidence suggests that the rate of decline in estimated glomerular filtration rate (eGFR), the patient's psychiatric stability, and the availability of alternative treatment options should all be considered when making clinical decisions. Furthermore, studies indicate that lithium therapy may still be feasible in patients undergoing hemodialysis when appropriate dose adjustments and frequent serum lithium monitoring are implemented (3).

The treatment of bipolar disorder in patients with organ failure should be individualized. Multidisciplinary collaboration among psychiatrists, nephrologists, and gastroenterologists is essential. The primary therapeutic goal is to achieve an optimal balance between maintaining psychiatric stability and preserving organ function. In clinical practice, the most critical question is whether the patient's risk of medication toxicity or the risk of bipolar relapse is more clinically

significant. Accordingly, regular biochemical monitoring, individualized dose adjustments, and comprehensive patient education constitute indispensable components of treatment.

References

1. Gitlin M. Lithium and the kidney: an updated review. Drug Saf 2016; 39:55-64.
2. Verrotti A, D'Egidio C, Mohn A, Coppola G, Parisi P, Chiarelli F. Valproate-induced hepatotoxicity and hyperammonemia. Epilepsy Res 2014;108:1190-1198.
3. Menon V, Ramdas R, Samir Kumar P. Management of psychiatric disorders in patients with hepatic and gastrointestinal diseases. Indian J Psychiatry 2022; 64: S379-S393.

Metacognitive Therapy: Intervening in Worry/Rumination Cycles and Metacognitive Processes in Anxiety-Related Conditions

Sedat Batmaz
Social Sciences University of Ankara

Anxiety-related conditions are heterogeneous in symptom presentation, yet many are maintained by a limited set of repetitive self-regulatory processes. In routine psychiatric practice, treatment selection is often guided primarily by diagnosis; however, a more clinically useful approach may also consider the mechanisms that maintain distress in the individual patient. This educational talk will introduce Metacognitive Therapy (MCT) as a process-focused intervention for anxiety-related presentations in which persistent worry, rumination, threat monitoring, maladaptive coping strategies, and dysfunctional metacognitive beliefs are central to symptom maintenance.

The session is designed for psychiatry residents and early-career specialists and will address the practical question of which therapy may be more suitable for which patient, and at what point in treatment. Using brief case-based examples, the talk will illustrate how MCT conceptualizes psychological distress through the Cognitive Attentional Syndrome (CAS), a pattern characterized by perseverative negative thinking, attentional fixation on threat, and unhelpful coping responses. Particular emphasis will be placed on recognizing clinical clues suggesting that MCT may be especially relevant, such as prominent meta-worry, chronic rumination, self-focused attention, reassurance seeking, mental control strategies, and repeated failure of content-based cognitive disputation.

At the same time, the talk will present a balanced overview of the current place of MCT across anxiety-related conditions. For generalized anxiety disorder, MCT has a comparatively stronger evidence base and may be considered a particularly relevant option in patients with persistent worry and metacognitive beliefs about uncontrollability and danger. In social anxiety disorder, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, and health anxiety, MCT appears promising for selected patients, especially when repetitive negative thinking and threat monitoring are pronounced; however, its evidence base remains more limited than that of established first-line treatments in several of these conditions. Therefore, the presentation will explicitly situate MCT alongside current treatment guidelines and gold-standard interventions such as cognitive behavioural therapy (CBT), exposure-based approaches, exposure and response prevention (ERP), and trauma-focused interventions.

The overall aim is not to present MCT as a universal alternative, but to help clinicians make more precise, mechanism-informed treatment decisions while remaining transparent about areas in which the empirical support for MCT is stronger or still emerging.

References

Nordahl HM, Wells A. Metacognitive therapy for generalized anxiety disorder: A systematic review and meta-analysis. J Anxiety Disord 2023;95:102668.
National Institute for Health and Care Excellence. Generalised anxiety disorder and panic disorder in adults: management (CG113). London: NICE; 2011.
National Institute for Health and Care Excellence. Social anxiety disorder: recognition, assessment and treatment (CG159). London: NICE; 2013.

Working with Emotions in Cognitive Behavioural Psychotherapies

Sedat Batmaz
Social Sciences University of Ankara

Emotions are central to both the development and maintenance of psychological disorders, yet in clinical practice they are sometimes approached either too narrowly as symptoms to be reduced or too diffusely as experiences to be explored without sufficient therapeutic direction. This educational talk will discuss how emotions can be understood and addressed within Cognitive Behavioural Therapy (CBT) and related cognitive behavioural psychotherapies in a clinically practical, formulation-driven, and evidence-informed manner.

The presentation will emphasize that working with emotions in CBT does not simply mean helping patients calm down. Rather, it involves identifying the links among triggering situations, appraisals, bodily responses, action tendencies, attentional processes, avoidance patterns, and interpersonal consequences. From this perspective, fear, sadness, shame, guilt, anger, and disgust are not treated as isolated affective states, but as experiences embedded in broader cognitive, behavioural, physiological, and contextual systems. The session will highlight how emotional distress may be maintained by maladaptive beliefs, safety behaviours, experiential avoidance, repetitive negative thinking, self-criticism, and difficulties in emotional awareness or differentiation.

Using clinical examples, the talk will review how therapists can work with emotions at different stages of treatment. First, emotions must be accurately recognized, named, and placed within an individualized case formulation. Second, emotional responses should be linked to the patient's interpretations, predictions, and behavioural strategies. Third, intervention should target the processes that maintain problematic emotional cycles. These may include cognitive restructuring of dysfunctional appraisals, behavioural experiments, exposure-based procedures, response prevention, attention training, reduction of avoidance, and strategies that enhance emotional tolerance and adaptive regulation. Particular attention will be given to the distinction between validating an emotion and confirming the beliefs that maintain it, as well as to the clinical importance of helping patients approach rather than over-control or chronically avoid emotional experience.

The talk will also underline that different CBT traditions may place different emphasis on emotional processing, acceptance, exposure, self-compassion, or metacognitive change. Rather than presenting these as competing positions, the session will propose a clinically integrative CBT perspective in which emotions are addressed through mechanism-based formulation and intervention selection. The overall aim is to help clinicians work with emotions in a way that is

empathic, conceptually clear, and therapeutically active, while preserving the structured and collaborative spirit of cognitive behavioural practice.

References

1. Beck JS. Cognitive Behavior Therapy: Basics and Beyond. 3rd ed. New York: Guilford Press; 2020.
2. Barlow DH, Farchione TJ, Bullis JR, Gallagher MW, Murray-Latin H, Sauer-Zavala S, ve ark. Unified Protocol for Transdiagnostic Treatment of Emotional Disorders: Therapist Guide. 2nd ed. New York: Oxford University Press; 2018.
3. Leahy RL. Emotional Schema Therapy. New York: Guilford Press; 2015.

The Clinical Function of Transition and Discharge Summaries from an Adult Psychiatry Perspective

Sedat Batmaz
Social Sciences University of Ankara

The transfer of care from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS) is not a simple administrative handover, but a clinically sensitive process that may significantly influence continuity of care, treatment engagement, and long-term outcome. From an adult psychiatry perspective, this transition period is often marked by loss of familiar therapeutic relationships, changes in service thresholds, differing treatment cultures, and increased expectations regarding autonomy and self-management. Unless the process is planned carefully, young people with ongoing psychiatric needs may disengage from services, experience fragmented care, or present later in crisis. This educational talk will examine the clinical function of transition and discharge summaries in the transfer from child and adolescent psychiatry to adult psychiatry.

The presentation will emphasize that transition should be understood as a longitudinal clinical process rather than a single transfer event. In this framework, discharge summaries and transition notes are not merely medico-legal documents or administrative requirements. They are core clinical tools that can preserve developmental, diagnostic, therapeutic, and relational continuity across services. A useful transition summary should communicate not only diagnoses, medications, and previous admissions, but also the young person's developmental history, functional profile, formulation, risk patterns, previous responses to treatment, family involvement, adherence difficulties, communication style, strengths, and current goals. In this sense, a well-prepared epikriz functions as a bridge between services rather than a retrospective record of past care.

The talk will also discuss how adult psychiatrists can use transition documentation more actively in clinical practice. A clinically meaningful transition summary helps the receiving team identify what has been effective or ineffective, anticipate predictable ruptures in engagement, and avoid unnecessary repetition of assessments that may burden the young person. It may also support more realistic treatment planning by clarifying whether the main clinical need is continued specialist care, stepped-down follow-up, crisis prevention, psychosocial support, or coordinated primary care involvement. Particular attention will be given to the importance of collaborative planning, joint meetings when possible, and documentation that reflects the young person's own preferences, concerns, and expectations regarding adult services.

The overall aim of the talk is to reframe transition and epikriz writing as essential elements of good psychiatric care rather than peripheral paperwork. From an adult psychiatry perspective, the quality of transition documentation may directly shape whether transfer becomes a point of discontinuity or a platform for sustained therapeutic engagement.

References

1. National Institute for Health and Care Excellence. Transition from children's to adults' services for young people using health or social care services (NG43). London: NICE; 2016.
2. National Institute for Health and Care Excellence. Transition from children's to adults' services (QS140). London: NICE; 2016.
3. Cleverley K, Rowland E, Bennett K, Jeffs L, Gore D. Identifying core components and indicators of successful transitions from child to adult mental health services: a scoping review. Eur Child Adolesc Psychiatry 2020;29:107-121.

Recurrent Suicidal Behaviour in Borderline Personality Disorder and Its Clinical Management

Sedat Batmaz
Social Sciences University of Ankara

Recurrent suicidal behaviour is one of the most clinically challenging features of Borderline Personality Disorder (BPD). It is often embedded in a broader pattern of affective instability, interpersonal hypersensitivity, impulsivity, identity disturbance, and recurrent crises, which complicates both risk assessment and treatment planning. In routine practice, suicidal behaviour in BPD may be mismanaged either through underestimation, because it is seen as “chronic” or “manipulative,” or through overreaction, leading to repeated crisis-driven interventions that may inadvertently reinforce maladaptive patterns. This educational talk will address how recurrent suicidal behaviour in BPD can be understood and managed within a structured, evidence-informed, and non-stigmatizing clinical framework.

The presentation will emphasize that suicidal behaviour in BPD should not be reduced to a single function or motive. Rather, it typically emerges from the interaction of intense emotional pain, perceived interpersonal rupture or abandonment, hopelessness, cognitive constriction, poor distress tolerance, and difficulties in self-regulation. Accordingly, effective clinical management requires more than acute risk containment. It calls for a longitudinal formulation that examines the antecedents, functions, meanings, and maintaining interpersonal contexts of suicidal crises. Particular attention will be given to the distinction between episodic high-risk states and chronic baseline vulnerability, as well as to the importance of repeated, collaborative, and context-sensitive suicide risk assessment.

Using case-based examples, the talk will review key principles of clinical management. These include maintaining a clear and empathic therapeutic stance, avoiding pejorative or dismissive formulations, identifying proximal triggers and warning signs, addressing co-occurring psychiatric conditions, limiting fragmented and inconsistent crisis responses, and developing a coherent treatment plan shared by the clinical team. The session will also discuss the place of evidence-based psychotherapies, especially structured approaches that directly target emotional dysregulation, self-harm, and suicidal crises. At the same time, the role and limits of pharmacotherapy will be addressed, with emphasis on the fact that medications should not be treated as primary interventions for the core pathology of BPD.

The overall aim of the talk is to help clinicians approach recurrent suicidal behaviour in BPD with greater precision, consistency, and therapeutic confidence. Rather than viewing these patients only through the lens of immediate crisis, the presentation will advocate a person-

centred approach that integrates acute safety management with sustained psychotherapeutic care, team coordination, and respect for the patient's dignity.

References

1. Keepers GA, Fochtmann LJ, Amdur RL, ve ark. The American Psychiatric Association Practice Guideline for the Treatment of Patients With Borderline Personality Disorder. Am J Psychiatry 2024;181(11):1015-1021.
2. National Institute for Health and Care Excellence. Borderline personality disorder: recognition and management (CG78). London: NICE; 2009.
3. National Institute for Health and Care Excellence. Self-harm: assessment, management and preventing recurrence (NG225). London: NICE; 2022.

Conceptual and Diagnostic Challenges in the Classification of Eating Disorders

Gamze Usta Sağlam[1]
[1] Istanbul University–Cerrahpaşa, Cerrahpaşa Faculty of Medicine, Department of Psychiatry, Istanbul, Türkiye

Eating disorders constitute a heterogeneous group of psychiatric conditions characterized by marked disturbances in body image, eating behavior, and weight-related cognitions, often leading to significant medical morbidity. Persistent challenges in the early identification of these disorders, alongside ongoing difficulties in diagnostic delineation and classification within clinical practice, remain highly salient. The substantial overlap across symptom clusters and the notable diagnostic fluidity observed between categories suggest that eating disorders may be more appropriately conceptualized along a dimensional continuum rather than as discrete, categorical entities. This perspective raises critical questions regarding the extent to which current classificatory systems adequately capture clinical reality.

Prior to the introduction of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) and the International Classification of Diseases, 11th Revision (ICD-11), a considerable proportion of clinically significant cases were subsumed under the category of “eating disorders not otherwise specified,” thereby underscoring fundamental limitations in the inclusivity and specificity of earlier diagnostic frameworks. The DSM-5 sought to address these shortcomings through the relaxation of diagnostic criteria for anorexia nervosa and bulimia nervosa, as well as by establishing binge-eating disorder as a distinct diagnostic entity.

Divergences between diagnostic systems are particularly pronounced in the conceptualization of anorexia nervosa. Within ICD-11, the explicit presence of a fear of weight gain is not a mandatory criterion, thereby facilitating diagnosis in cases where weight loss is rationalized through somatic explanations, where insight is limited, or where fear of weight gain does not find expression due to cultural factors. Furthermore, the inclusion of categories reflecting illness trajectory—such as individuals undergoing significant weight loss who have not yet reached a markedly low body weight, as well as “anorexia nervosa in recovery”—may enhance the clinical sensitivity of ICD-11. These distinctions illustrate the ongoing tension between maximizing clinical sensitivity and maintaining conceptual precision within diagnostic systems.

The introduction of avoidant/restrictive food intake disorder (ARFID) in DSM-5 represents a significant advancement in recognizing that restrictive eating patterns may arise independently of body image disturbance or weight-related psychopathology. While this diagnosis provides a necessary framework for previously unclassified presentations, it simultaneously highlights the

permeability of diagnostic boundaries, particularly in its differentiation from non-fat-phobic anorexia nervosa.

Finally, the ongoing debate regarding the relative merits of categorical versus dimensional approaches to psychiatric classification will be considered. The strengths and limitations of current diagnostic systems will be critically appraised with respect to their clinical utility, applicability in research contexts, and conceptual coherence.

This presentation aims to critically examine the classification of eating disorders within contemporary diagnostic systems, with a particular focus on their strengths, limitations, and the diagnostic ambiguities that continue to challenge clinical practice.

TMS in the Treatment of Depression with Comorbid Psychiatric Disorders

Büşra Uçar Bostan
Bakırköy Prof. Dr. Mazhar Osman Training and Research Hospital for Psychiatry, Neurology and Neurosurgery

Major depressive disorder (MDD) is one of the leading contributors to the global burden of disease and frequently co-occurs with other psychiatric disorders. Comorbid conditions such as anxiety disorders, post-traumatic stress disorder, and obsessive-compulsive disorder increase the clinical severity of depression, increase treatment resistance, and negatively affect prognosis. In these patient populations, standard pharmacotherapy and psychotherapy approaches may be insufficient. Recent studies indicate that transcranial magnetic stimulation (TMS) can significantly reduce not only depressive symptoms but also accompanying psychiatric symptoms, thereby offering a more integrated treatment option in this clinical context.
In the presence of psychiatric comorbidities accompanying MDD, the response to pharmacotherapy may be more limited, time to remission may be prolonged, and the risk of relapse may be increased. This clinical context underscores the need for alternative and/or adjunctive treatment modalities in addition to standard interventions for this patient group. In this context, recent studies have reported that TMS provides significant reductions not only in depressive symptoms but also in comorbid psychiatric symptom domains, and is associated with overall clinical improvement; these findings suggest that TMS may contribute to meaningful clinical recovery in patients with comorbid psychiatric conditions.(Chou et al., 2021)
Beyond unipolar depression, TMS has also emerged as a promising option in bipolar depression, contributing to the reduction of depressive symptoms and supporting mood stabilization. Given the limited number of pharmacological options approved for bipolar depression and the poorly tolerated side-effect profiles of existing medications, TMS is positioned as a robust alternative or adjunctive treatment. Furthermore, recent meta-analytic findings indicate that the risk of treatment-emergent manic switch is low and comparable to placebo conditions, supporting the favorable safety profile of TMS in this population.(Ventura et al., 2026)
When planning TMS for patients with depression and comorbid psychiatric disorders, a more individualized approach should be adopted by considering the predominant symptom clusters and comorbid diagnoses. Within this framework, determining stimulation frequency, target cortical region, protocol parameters, and coil type in line with the clinical profile may yield clinically meaningful improvements not only in depressive symptoms but also in comorbid psychiatric symptom domains.(Thompson, 2020)

Overall, TMS stands out as a personalized intervention that may help alleviate treatment resistance and reduce symptom burden in MDD with psychiatric comorbidity. As the evidence base continues to expand, the role of TMS in treatment guidelines and routine clinical practice for such complex presentations is expected to become increasingly well-defined.

References

1. Chou, P. H., Lin, Y. F., Lu, M. K., Chang, H. A., Chu, C. S., Chang, W. H., Kishimoto, T., Sack, A. T. & Su, K. P. 2021. Personalization of Repetitive Transcranial Magnetic Stimulation for the Treatment of Major Depressive Disorder According to the Existing Psychiatric Comorbidity. Clin Psychopharmacol Neurosci, 19**,** 190-205.
2. Thompson, L. 2020. Treating major depression and comorbid disorders with transcranial magnetic stimulation. J Affect Disord, 276**,** 453-460.
3. Ventura, F., Frias, P., Rodrigues Da Silva, D., Mcgirr, A., Cotovio, G. & Oliveira-Maia, A. J. 2026. Efficacy, Effectiveness, and Safety of Transcranial Magnetic Stimulation for Bipolar Depression: A Systematic Review and Meta-Analysis. Biol Psychiatry Glob Open Sci, 6**,** 100618.

Ethical Boundaries and Patient Privacy in Psychiatrists' Social Media Use: Indirect Diagnostic Language, Generalized Clinical Messages, and Re-identification Risk

Yalçın Kahya
Rumeli University İstanbul

The rapid expansion of social media has created a new professional arena for psychiatrists. Over 60% of psychiatrists are estimated to be active on social platforms, and mental health content continues to reach unprecedented audiences — with over 100 billion views on TikTok alone. While digital platforms offer genuine opportunities for psychoeducation and reducing stigma, they also introduce complex ethical challenges that have yet to be sufficiently addressed in psychiatric training or institutional policy.

This presentation examines three interrelated risks: indirect diagnostic language, generalized clinical messaging, and re-identification. Indirect diagnostic language refers to any narrative that, although it does not directly name a patient, contains clinical, demographic, or contextual cues sufficient for recognition. Phrases such as "a patient I saw last week" or "the young women I frequently encounter" may seem innocuous but carry a meaningful risk of disclosure when combined — age, gender, occupation, and chief complaint together can render an individual uniquely identifiable to their own social circle. This is known as re-identification risk, and anonymization alone does not eliminate it.

Generalized clinical messages present a separate but equally important concern. Content framed around diagnostic labels used as social descriptors — such as "signs of a narcissistic partner" or "being in a relationship with someone borderline" — contributes to stigmatization and fosters inaccurate self-diagnosis among general audiences. Such content may appear educational but often reflects clinical labeling rather than evidence-based communication.

Guidance from the American Psychiatric Association (APA) and the World Psychiatric Association (WPA) is unequivocal: patient confidentiality, boundary management, and informed consent apply in digital environments without exception. The APA Ethics Committee has clarified that patient information may not be shared without explicit written consent, and that anonymization is insufficient when re-identification is plausible. Turkey's legal framework — including the Patient Rights Regulation, Turkish Medical Association (TTB) ethics principles, and the Personal Data Protection Law (KVKK) — similarly classifies health data as sensitive personal data requiring explicit consent before any disclosure.

The clinical implications extend beyond legal compliance. When patients recognize themselves — or believe they have been recognized — in a clinician's public content, the therapeutic

alliance suffers irreparable damage. The clinician's digital presence may also activate transference patterns, complicating the clinical relationship.

This presentation proposes a practical framework for reflective content evaluation, summarized as five questions to consider before any clinical sharing: whether a specific patient may be identifiable, whether written informed consent has been obtained, whether the content serves evidence-based education rather than self-expression, whether stigmatizing language is present, and whether the content would withstand scrutiny by a colleague or ethics committee. Digital visibility is a legitimate professional right — but one that demands ethical responsibility. Maintaining boundaries in the digital domain does not diminish clinical identity; it reinforces it.

References

1. American Psychiatric Association. Commentary on Ethics in Practice. Washington, DC: APA; 2015.
2. World Psychiatric Association. Code of Ethics for Psychiatry. WPA; 2021.
3. Zalpuri I, Cowperthwaite MC, Chan ES, DeJong SM, Beresin EV, et al. Expert consensus on entrustable professional activities for clinician social media use. Acad Psychiatry. 2025.

Functional Neuroanatomy of Sexuality: Sexual Dysfunctions from the Perspective of Brain Imaging and Neural Networks

Eldem GÜVERCİN
Republic of Türkiye Ministry of Health İzmir Atatürk Training and Research Hospital
Dokuz Eylül University Department of Neuroscience

Sexuality cannot be explained solely in terms of responses occurring in the genital organs; rather, it is a multilayered neurobiological process involving motivation, reward processing, emotion regulation, attention, body awareness, and executive control. In recent years, functional magnetic resonance imaging (fMRI), positron emission tomography (PET), and structural connectivity studies have shown that sexual arousal is governed not by an isolated "center" in the brain, but by large-scale neural networks that interact with one another. In particular, the insula, anterior cingulate cortex, amygdala, hypothalamus, striatum, orbitofrontal cortex, and prefrontal regions play key roles in the emergence of sexual desire, the appraisal of sexual stimuli, the regulation of autonomic responses, and the modulation of behavioral inhibition (Georgiadis & Kringelbach, 2012).

Neuroimaging findings suggest that sexual function can be conceptualized across three principal levels: the reward–motivation network, the emotional salience network, and the cognitive control network. While the ventral striatum and dopaminergic circuits are prominent within the reward and motivation component, the insula and anterior cingulate cortex within the salience network are particularly involved in detecting bodily arousal and generating the subjective sexual experience. By contrast, medial and dorsolateral prefrontal regions shape higher-order cognitive processes such as social context, self-control, and performance anxiety. Sexual response should therefore be understood not simply in terms of whether "arousal is present or absent," but as the integrated output of reward expectancy, attentional allocation, anxiety level, and the integration of bodily signals (Stoléru et al., 2012).

This network perspective also makes important contributions to understanding sexual dysfunctions. In hypoactive sexual desire disorder, reduced sensitivity within reward circuits and increased activity in inhibitory networks have been proposed; in erectile dysfunction, emotional burden, performance anxiety, and impaired autonomic regulation are thought to produce functional imbalances within corticolimbic networks. Similarly, distinct patterns of activation in regions involved in attention, emotion regulation, and interoceptive awareness have been reported in female sexual dysfunctions. Within this framework, modern neuroimaging makes it possible to evaluate sexual dysfunctions not merely through the psychogenic–organic dichotomy, but within a network-based neuropsychobiological model. Clinically, this approach

may provide a basis for developing more targeted psychotherapeutic, pharmacotherapeutic, and neuromodulatory interventions (Poeppl et al., 2016).

References

1. Georgiadis, J. R., & Kringelbach, M. L. (2012). The human sexual response cycle: brain imaging evidence linking sex to other pleasures. Progress in neurobiology, 98(1), 49–81. https://doi.org/10.1016/j.pneurobio.2012.05.004
2. Stoléru, S., Fonteille, V., Cornélis, C., Joyal, C., & Moulier, V. (2012). Functional neuroimaging studies of sexual arousal and orgasm in healthy men and women: a review and meta-analysis. Neuroscience and biobehavioral reviews, 36(6), 1481–1509. https://doi.org/10.1016/j.neubiorev.2012.03.006
3. Poeppl, T. B., Langguth, B., Rupprecht, R., Safron, A., Bzdok, D., Laird, A. R., & Eickhoff, S. B. (2016). The neural basis of sex differences in sexual behavior: A quantitative meta-analysis. Frontiers in neuroendocrinology, 43, 28–43. https://doi.org/10.1016/j.yfrne.2016.10.001

Treatment-Resistant Depression: Definition and Characteristics

Eldem GÜVERCİN
Republic of Türkiye Ministry of Health İzmir Atatürk Training and Research Hospital
Dokuz Eylül University Department of Neuroscience

Treatment-resistant depression (TRD) refers to the failure to achieve an adequate clinical response despite at least two different antidepressant trials administered at an adequate dose and for an adequate duration. However, some classifications of TRD are based on partial response, whereas others consider only complete nonresponse. Therefore, TRD should be regarded not as a single category but as a clinical spectrum that varies according to the degree of inadequate treatment response (Conway et al., 2017).

In terms of its clinical characteristics, TRD is associated with a longer duration of depressive symptoms, more pronounced functional impairment, an increased risk of recurrence, and a higher frequency of suicidal ideation or behavior. Anxiety disorders, substance use disorders, personality pathology, chronic pain, thyroid disease, and other medical comorbidities may also increase the risk of TRD. The likelihood of developing treatment resistance is considered higher particularly in depressive presentations characterized by early onset, severe course, psychotic features, or melancholic symptoms. In addition, misdiagnosis, inadequate treatment duration, subtherapeutic dosing, medication nonadherence, and pharmacokinetic differences make it essential to distinguish “true resistance” from “pseudo-resistance” (Souery et al., 2006).

From a neurobiological perspective, TRD has been associated with complex mechanisms extending beyond monoaminergic systems. Glutamatergic neurotransmission, neuroplasticity, inflammation, dysregulation of the hypothalamic-pituitary-adrenal axis, and abnormalities in reward circuitry are among the potential mechanisms involved in the development of treatment resistance. These findings indicate that models based solely on serotonin or noradrenaline deficiency are insufficient to explain TRD (Caraci et al., 2018).

When diagnosing TRD in clinical practice, the accuracy of the diagnosis, the possibility of bipolarity, comorbid conditions, treatment adherence, and the adequacy of previous treatment trials should first be carefully reviewed. Many cases that appear to be treatment resistant may in fact be related to inadequate treatment trials, diagnostic uncertainty, or ongoing environmental factors. Therefore, TRD should not be understood simply as a situation in which “the medication did not work”; rather, it should be approached as a heterogeneous and multidimensional clinical condition requiring a comprehensive biopsychosocial assessment. This approach is fundamental to the development of personalized treatment strategies. This

presentation aims to provide a framework for the recognition and clinical management of TRD by addressing its definition and principal characteristics.

References

1. Caraci, F., Calabrese, F., Molteni, R., Bartova, L., Dold, M., Leggio, G. M., Fabbri, C., Mendlewicz, J., Racagni, G., Kasper, S., Riva, M. A., & Drago, F. (2018). International Union of Basic and Clinical Pharmacology CIV: The Neurobiology of Treatment-resistant Depression: From Antidepressant Classifications to Novel Pharmacological Targets. Pharmacological reviews, 70(3), 475–504. https://doi.org/10.1124/pr.117.014977
2. Conway, C. R., George, M. S., & Sackeim, H. A. (2017). Toward an Evidence-Based, Operational Definition of Treatment-Resistant Depression: When Enough Is Enough. JAMA psychiatry, 74(1), 9–10. https://doi.org/10.1001/jamapsychiatry.2016.2586
3. Souery, D., Papakostas, G. I., & Trivedi, M. H. (2006). Treatment-resistant depression. The Journal of clinical psychiatry, 67 Suppl 6, 16–22.

A Neurobiological Approach to Cognitive Distortions and Biased Decision-Making in Behavioral Addictions

Eldem GÜVERCİN
Republic of Türkiye Ministry of Health İzmir Atatürk Training and Research Hospital
Dokuz Eylül University Department of Neuroscience

Behavioral addictions are clinical conditions characterized by recurrent and compulsive reward-seeking in the absence of substance use, resulting in functional impairment. Gambling disorder is a well-defined example of this group, while internet gaming disorder and other problematic digital behaviors have also been associated with similar neurocognitive mechanisms. One of the central problems in these disorders is the distorted evaluation of reward probability and the prioritization of anticipated short-term gains over long-term losses. Cognitive distortions such as the “illusion of control,” the “gambler’s fallacy,” the belief that losses can be recovered, and selective recall play a prominent role in this process. Individuals may perceive patterns in random events, overestimate the influence of their own skill on chance outcomes, and believe that the next attempt will be “corrective” despite repeated losses (Clark, 2010).

From a neurobiological perspective, these distortions are not merely psychological errors but behavioral manifestations of functional imbalances in reward-processing and decision-making circuits. The ventral striatum, orbitofrontal cortex, ventromedial prefrontal cortex, anterior cingulate cortex, insula, and amygdala play key roles in reward anticipation, choice under uncertainty, error monitoring, and sensitivity to loss. In behavioral addictions, frontostriatal circuit dysfunction has been reported in association with heightened sensitivity to anticipated reward, persistence despite losses, and insufficient responsiveness to punishment. When combined with increased impulsivity and weakened cognitive control, these abnormalities reinforce disadvantageous patterns of decision-making (Goudriaan et al., 2004).

Clinically, this model is important because correcting cognitive distortions may require not only psychoeducation but also comprehensive interventions targeting decision-making processes, impulse control, and reward expectancy. Accordingly, a neurocognitive approach that considers cognitive distortions alongside dysfunction in neural networks is gaining increasing importance in the assessment of behavioral addictions. This presentation aims to examine cognitive distortions in behavioral addictions from a neurobiological perspective.

References

1. Clark, L. (2010). Decision-making during gambling: An integration of cognitive and psychobiological approaches. Philosophical Transactions of the Royal Society of London. Series B, Biological Sciences, 365(1538), 319–330. https://doi.org/10.1098/rstb.2009.0147
2. Goudriaan, A. E., Oosterlaan, J., de Beurs, E., & van den Brink, W. (2004). Pathological gambling: A comprehensive review of biobehavioral findings. Neuroscience & Biobehavioral Reviews, 28(2), 123–141.

Red Flags in CLP: Psychiatric Emergencies in Clinical Settings from Diagnosis to Intervention
The Agitated Patient: Safe and Effective Management Approaches

İrem Ekmekci
Gazi University School of Medicine, Department of Psychiatry

Agitation is a frequently encountered clinical phenomenon in general hospital settings and represents a significant portion of Consultation-Liaison Psychiatry (CLP) referrals. Rather than being a primary psychiatric diagnosis, agitation in the medically ill is often a manifestation of an underlying physiological derangement. This presentation aims to provide a structured clinical framework for managing agitation, emphasizing the transition from symptomatic control to etiological investigation.

The initial assessment of an agitated patient requires a rapid differentiation between behavioral emergencies and medical emergencies. In the CLP context, the prevalence of delirium remains high, particularly among geriatric populations and patients in intensive care units. Clinical "red flags," such as acute onset, fluctuating consciousness, and vital sign instability, must immediately direct the clinician toward organic causes including hypoxia, electrolyte imbalances, infections, or metabolic disturbances. The fundamental principle of CLP is that the question "Why is the patient agitated?" must precede "How do I sedate the patient?"

Management strategies should follow a hierarchical approach, beginning with environmental modifications and verbal de-escalation. When these are insufficient, pharmacological interventions are necessitated. Haloperidol remains a cornerstone in CLP due to its minimal anticholinergic profile and availability of intravenous (IV) administration. However, the risk of QTc prolongation necessitates close electrocardiographic monitoring. Atypical antipsychotics such as olanzapine and quetiapine offer alternatives but carry specific risks like orthostatic hypotension or interactions with parenteral benzodiazepines. The use of benzodiazepines should be restricted to alcohol/benzodiazepine withdrawal or catatonia, as they may cause paradoxical agitation or exacerbate delirium in the elderly. Recent evidence also highlights the role of alpha-2 agonists, such as dexmedetomidine, in managing agitation without respiratory depression in critical care settings.

In conclusion, successful management of agitation in the general hospital depends on a multidisciplinary approach, prioritizing the identification of the underlying medical trigger while ensuring the safety of the patient and staff.

References

1. Zeller SL, Rhoades RW. Systematic reviews of assessment and management of agitation in the medical setting. Med Clin North Am 2010; 94(6):1141-1154.
2. Inouye SK, Westendorp RG, Saczynski JS. Delirium in elderly people. Lancet 2014; 383(9920):911-922.
3. Wilson MP, Pepper D, Currier GW, Holloman GH Jr, Feifel D. The psychopharmacology of agitation: Consensus statement of the American Association for Emergency Psychiatry Project BETA Psychopharmacology Workgroup. West J Emerg Med 2012; 13(1):26-34.

Approach to Autoimmune Dementia Syndromes

Yağmur Kır
Department of Psychiatry, Ankara University Faculty of Medicine, Ankara, Türkiye

Although dementia syndromes have traditionally been regarded as consequences of neurodegenerative processes, accumulating evidence over the past decade suggests that immune-mediated mechanisms may contribute to the pathogenesis of a subset of dementias. The recognition that autoimmune dementia may be reversible with appropriate immunomodulatory treatment has substantially increased the importance of early diagnosis and timely intervention.

Autoimmune encephalitis is clinically characterized by subacute cognitive decline, altered mental status, and psychiatric symptoms, frequently accompanied by seizures, new focal neurological deficits, or inflammatory abnormalities detected in cerebrospinal fluid (CSF) or brain imaging. In patients presenting with suspected dementia, several clinical “red flags” should raise suspicion for an underlying autoimmune encephalitis. These include rapidly progressive cognitive deterioration, the presence of subtle seizures, and ancillary test abnormalities that are atypical for neurodegenerative disorders (1).

The spectrum of autoantibodies associated with autoimmune encephalitis demonstrates considerable heterogeneity with respect to the clinical manifestations of cognitive impairment. Different antibody subtypes have been associated with distinct patterns of cognitive and behavioral dysfunction, suggesting that autoimmune dementia should be viewed not as a single disease entity but rather as a group of antibody-associated syndromes. Limbic involvement with predominant memory impairment is particularly characteristic of LGI1 antibody-associated encephalitis, whereas N-methyl-D-aspartate receptor (NMDAR) antibody-associated encephalitis more commonly presents with behavioral changes and prominent psychiatric symptoms. In contrast, encephalitides associated with GABA receptor antibodies may involve memory, executive functions, and behavioral domains simultaneously (2). These distinct cognitive and behavioral profiles highlight the clinical heterogeneity of autoimmune dementia.

A comprehensive, multimodal diagnostic approach is essential. Brain imaging, particularly magnetic resonance imaging (MRI), may reveal hyperintense signal abnormalities. In addition, cerebrospinal fluid (CSF) analysis and neuronal autoantibody testing constitute key components of the diagnostic workup. Electroencephalography (EEG) may also provide valuable diagnostic information, with diffuse slowing and epileptiform discharges being among the most commonly reported findings. Nevertheless, none of these diagnostic modalities is individually sufficient to

establish the diagnosis, and all findings should be interpreted within the context of the patient's overall clinical presentation.

One of the most important features of autoimmune encephalitis-related dementia is its potential reversibility when diagnosed and treated promptly. Immunomodulatory therapies can result in substantial improvement in cognitive function. Currently available treatment options include corticosteroids, intravenous immunoglobulin (IVIG), plasma exchange, and rituximab (3).

In conclusion, autoimmune dementia is an increasingly recognized, potentially treatable condition that should be distinguished from neurodegenerative dementias. Investigation for an autoimmune etiology is particularly warranted in patients with subacute onset, fluctuating clinical course, or dementia accompanied by neurological and psychiatric manifestations, as early recognition and appropriate treatment may significantly improve clinical outcomes.

References

1. Bastiaansen AEM, van Steenhoven RW, de Bruijn MAAM, et al. (2021). Autoimmune Encephalitis Resembling Dementia Syndromes. Neurol Neuroimmunol Neuroinflamm. 8(5). doi:10.1212/NXI.0000000000001039.
2. Hansen N. (2025). Update on autoimmune dementia and its precursors. Behav Brain Res. 482:115460. doi:10.1016/j.bbr.2025.115460.
3. Hermann P, Zerr I. (2022). Rapidly progressive dementias—aetiologies, diagnosis and management. Nat Rev Neurol. 18(6):363–376. doi:10.1038/s41582-022-00659-0.

Approach to Autoimmune Psychosis and Catatonia

Rifat Serav İlhan
Department of Psychiatry, Ankara University Faculty of Medicine, Ankara, Türkiye

Autoimmune psychosis has emerged as an increasingly important clinical concept in recent years, supported by growing evidence that psychiatric symptoms may result from immune-mediated mechanisms. The recognition of psychiatric-onset forms of autoimmune encephalitis has highlighted the need to investigate autoimmune etiologies in patients presenting with acute or subacute psychosis. Catatonia may also occur within this spectrum and has been shown to have a particularly strong association with anti-N-methyl-D-aspartate receptor (anti-NMDAR) encephalitis.

The clinical presentation of autoimmune psychosis is typically characterized by an acute or subacute onset of paranoid ideation, hallucinations, agitation, and behavioral changes. In addition, catatonia, epileptic seizures, dyskinesias, autonomic dysfunction, and alterations in consciousness are among the common manifestations of autoimmune psychosis (1). Because many patients initially present with predominantly psychiatric symptoms, the diagnosis may easily be overlooked. One study reported that approximately 59% of patients with anti-NMDAR encephalitis initially presented with psychiatric symptoms (2). Further diagnostic evaluation for an autoimmune etiology is particularly recommended in patients with rapidly progressive illness, treatment-resistant psychosis, marked cognitive decline, epileptic seizures, or autonomic instability.

The spectrum of autoantibodies associated with autoimmune encephalitis exhibits considerable heterogeneity, which is reflected in the variability of psychiatric and behavioral manifestations. The clinical presentation and symptom clusters differ according to the underlying antibody subtype, suggesting that autoimmune psychosis should not be regarded as a single clinical entity but rather as a spectrum of distinct psychiatric phenotypes associated with different autoimmune mechanisms.

Electroencephalography (EEG), magnetic resonance imaging (MRI), and cerebrospinal fluid (CSF) analysis play essential roles in the diagnostic evaluation. In the appropriate clinical context, testing for neuronal cell surface antibodies represents an important component of the diagnostic workup and can provide valuable support for establishing the diagnosis.

Current consensus recommendations for the treatment of autoimmune encephalitis emphasize the prompt initiation of therapies aimed at removing circulating pathogenic antibodies. These first-line interventions include plasma exchange (plasmapheresis), immunoadsorption, and intravenous immunoglobulin (IVIG). Subsequently, immunosuppressive therapy with

corticosteroids or steroid-sparing agents such as azathioprine, methotrexate, or mycophenolate mofetil is recommended to suppress ongoing antibody production (3).

In conclusion, autoimmune psychosis is an increasingly recognized entity in psychiatric practice. Excluding an autoimmune etiology is of critical importance in patients presenting with atypical-onset psychosis, rapidly progressive clinical deterioration, or psychosis accompanied by neurological manifestations, as early diagnosis and appropriate treatment can substantially improve outcomes. Early recognition of autoimmune psychosis is essential not only for symptom control but also for preventing potentially reversible neuropsychiatric damage.

References

1. Herken J, Prüss H. (2017). Red Flags: Clinical Signs for Identifying Autoimmune Encephalitis in Psychiatric Patients. Front Psychiatry. 8:25. doi:10.3389/fpsyt.2017.00025.
2. Lejuste F, Thomas L, Picard G, et al. (2016). Neuroleptic intolerance in patients with anti-NMDAR encephalitis. Neurol Neuroimmunol Neuroinflamm. 3(5). doi:10.1212/NXI.0000000000000280.
3. Pollak TA, Lennox BR, Müller S, et al. (2020). Autoimmune psychosis: an international consensus on an approach to the diagnosis and management of psychosis of suspected autoimmune origin. Lancet Psychiatry. 7(1):93–108. doi:10.1016/S2215-0366(19)30290-1.

The Ontology of Mental Disorders: What Kind of Entities Are Mental Disorders?

Ahmet Batuhan Ermisket – Department of Psychiatry, Gazi University Faculty of Medicine, Ankara, Türkiye
Fadik Nazlı Saraç – Dorset Healthcare NHS Foundation Trust, St Ann's Hospital, Dorset, United Kingdom
Deniz Saraç – Pembroke College, University of Oxford, Oxford, United Kingdom
İbrahim Aylak – Private Practitioner, Reşit Galip Avenue No. 107/10, Ankara, Türkiye

The ontological status of mental disorders has emerged as one of the most important conceptual questions in contemporary psychiatry. Whether psychiatric diagnoses correspond to naturally occurring disease entities, socially constructed categories, or pragmatically useful clinical concepts has profound implications for psychiatric classification, research methodology, diagnostic reasoning, and patient care. Recent contributions from philosophers and psychiatric nosologists, particularly Kenneth Kendler, Peter Zachar, and Awais Aftab, have emphasized that these ontological assumptions are not merely abstract philosophical positions but fundamental commitments that shape everyday psychiatric practice.

This presentation examines contemporary debates regarding the ontological status of mental disorders through three interconnected themes. First, it critically evaluates reductionist accounts that equate psychiatric disorders with chemical imbalances or brain dysfunctions. Although neuroscience has considerably advanced our understanding of mental disorders, current evidence does not support the existence of disorder-specific neurobiological abnormalities capable of functioning as definitive diagnostic markers. Neuroimaging findings are typically derived from group-level differences with substantial overlap between affected and unaffected individuals, limiting their interpretation as indicators of pathology.

Second, the presentation distinguishes three claims that are often mistakenly treated as inseparable: that psychiatric disorders objectively exist, that their classifications correspond to natural divisions in reality, and that they are reducible to neurobiological dysfunctions. Building on the rejection of reductionism in the first part of the presentation, it raises the question of whether a commitment to reductionism is required for realism about psychiatric disorders. The central contention of the presentation is that realism about psychiatric disorders, and even the view that they constitute natural kinds, does not require neurobiological reductionism: higher-level phenomena can be objectively real without being exhaustively expressible in lower-level physical or biological terms. The scientific and ontological legitimacy of psychiatry therefore does not depend on whether its subject matter can be fully captured using the concepts of neuroscience.

Finally, the presentation discusses pragmatic and pluralistic approaches to psychiatric classification. The concept of practical kinds proposes that psychiatric diagnoses should primarily be understood as clinically useful categories that facilitate communication, improve diagnostic reliability, guide treatment planning, and support scientific investigation without necessarily corresponding to discrete entities in nature. Building upon this perspective, Kendler's explanatory pluralism and Aftab's critical and integrative pluralism offer complementary frameworks for understanding psychiatric disorders as complex, multi-level phenomena that require multiple explanatory perspectives. Rather than seeking a single ontological model applicable to every disorder, these approaches advocate conceptual flexibility while maintaining scientific rigor. The presentation concludes by considering how these contemporary philosophical developments may contribute to a more nuanced understanding of psychiatric diagnosis and promote a more reflective and clinically grounded psychiatric practice.

Novel Neuromodulation Techniques in Mood Disorders

Elif Burcu Ersungur Çelik
Islahiye State Hospital

In recent years, the field of neuromodulation in the treatment of mood disorders has expanded beyond conventional transcranial magnetic stimulation (TMS) approaches, incorporating more sophisticated and experimental techniques that target the dynamic properties of brain networks. This presentation will focus particularly on methods such as transcranial alternating current stimulation (tACS) and transcranial random noise stimulation (tRNS), which aim to modulate cortical oscillations and network-level synchronization, and their potential effects on depression. These techniques offer frequency-specific interventions that may influence both cognitive functions and emotional regulation by reorganizing abnormal rhythmic activity observed in fronto-limbic circuits. Current literature suggests that individualized frequency-targeting approaches may further enhance treatment response.

In addition, low-intensity focused ultrasound (FUS) represents an innovative and emerging method in the field of non-invasive neuromodulation. By enabling the precise targeting of deep brain structures with high spatial resolution, FUS may allow direct modulation of regions critically involved in the pathophysiology of depression. Although still in early clinical stages, preliminary findings are promising in terms of safety and target specificity.

Another key topic of this presentation will be Magnetic Seizure Therapy (MST). MST induces seizures in a more controlled and focal manner through magnetic fields, offering antidepressant efficacy comparable to electroconvulsive therapy (ECT) but with a potentially more favorable cognitive side-effect profile. It is considered a particularly important alternative for improving the balance between efficacy and tolerability in patients with treatment-resistant depression.

Furthermore, technological advancements aimed at increasing the accessibility of neuromodulation have led to the development of wearable brain stimulation systems. In this context, the FL-100, based on tDCS principles, has gained attention. While this approach may offer advantages in terms of treatment continuity and patient adherence, its clinical efficacy should be carefully evaluated on a device- and indication-specific basis.

In conclusion, this presentation highlights that neuromodulation in depression treatment is evolving toward a more targeted, personalized, and technologically integrated framework. However, it is evident that larger-scale, randomized controlled studies are needed to ensure the safe and effective integration of these innovative approaches into clinical practice (Brunoni et al., 2018; Davidson et al., 2024).

References

1. Brunoni AR, Sampaio-Junior B, Moffa AH, Aparício LV, Gordon P, Klein I, et al. Noninvasive brain stimulation in psychiatric disorders: a primer. Braz J Psychiatry. 2018 Oct 11;41(1):70–81.
2. Davidson B, Bhattacharya A, Sarica C, Darmani G, Raies N, Chen R, et al. Neuromodulation techniques – From non-invasive brain stimulation to deep brain stimulation. Neurotherapeutics. 2024 Feb 9;21(3):e00330.

Psychological Resilience in Patients with Cancer: Coping, Adaptation, and Post-traumatic Growth

Hayriye Dilek Hamurcu,
University of Health Sciences Türkiye,

Abdurrahman Yurtaslan Ankara Oncology Training and Research Hospital,
Psychiatry Clinic, Ankara, Türkiye

Cancer is not only a physical disease but also a multidimensional crisis with emotional, social, existential, and spiritual consequences. Despite major advances in cancer treatment, the emotional responses of patients remain strikingly similar across decades. From the time of diagnosis through treatment, recurrence, survivorship, and end-of-life care, patients and families may experience shock, denial, anger, bargaining, sadness, fear, and uncertainty. In psycho-oncology, distress is best understood as a continuum ranging from normative vulnerability, sadness, and fear to clinically significant anxiety, depression, social withdrawal, existential crisis, and impaired functioning. Because cancer-related stressors are often multiple, cumulative, and prolonged, distress may fluctuate over time and may not fit neatly within conventional diagnostic boundaries such as adjustment disorder.

Yet patients exposed to the same disease burden do not respond in the same way. Some develop marked distress and psychiatric morbidity, whereas others preserve psychological balance, sustain adaptive coping, and even report positive transformation (Cordova ve ark. 2017; George ve ark. 2023). This talk examines the factors that shape these divergent trajectories through the concepts of resilience, coping, adaptation, and post-traumatic growth (Tedeschi ve Calhoun 2004; Cordova ve ark. 2017; George ve ark. 2023). Resilience will be discussed as a dynamic process rather than a fixed trait, involving the capacity to maintain or regain psychological equilibrium in the face of medical and existential threat (George ve ark. 2023). Particular attention will be paid to protective factors such as social support, meaning, autonomy, prior coping experience, and spiritual resources. The presentation will also highlight high-risk periods for psychological deterioration, including diagnosis, hospitalization, major complications, treatment failure, recurrence, and the terminal phase across the illness trajectory. Finally, cancer will be considered not only as a source of distress but also, for some individuals, as a context for reassessing priorities, deepening relationships, and experiencing post-traumatic growth (Tedeschi ve Calhoun 2004).

A better understanding of cancer-related distress and resilience can improve clinical assessment, identify vulnerable periods, and support more timely psycho-oncological interventions for patients and families (Cordova ve ark. 2017; George ve ark. 2023).

References

1. George T, Shah F, Tiwari A, et al. Resilience in older adults with cancer: A scoping literature review. J Geriatr Oncol. 2023;14(1):101349.
2. Cordova MJ, Riba MB, Spiegel D. Post-traumatic stress disorder and cancer. Lancet Psychiatry. 2017;4(4):330-338.
3. Tedeschi RG, Calhoun LG. Posttraumatic growth: Conceptual foundations and empirical evidence. Psychol Inq. 2004;15(1):1-18.

The Boundaries Drawn by the Psychiatrist

Şahabettin Çetin
Pamukkale University Faculty of Medicine, Department of Psychiatry, Denizli

The boundaries of the physician-patient relationship are broadly defined by universal ethical principles, yet psychiatry requires additional care because treatment unfolds through privacy, emotional intensity, transference, asymmetry of power, and the structured frame of repeated encounters. For this reason, boundaries in psychiatry should not be understood as secondary rules surrounding treatment, but as part of the therapeutic process itself. They protect the patient, the psychiatrist, and the integrity of the clinical relationship. In psychiatric practice, an interaction that may appear similar to ordinary conversation is in fact highly structured by time, setting, role, confidentiality, distance, language, and responsibility. The distinction between the psychiatrist's professional identity and personal identity is therefore essential. The therapeutic value of the encounter depends not on the psychiatrist becoming personally available in unlimited ways, but on preserving a reliable frame in which the patient can think, feel, and speak safely. The literature has long distinguished between boundary crossings and boundary violations. Not every departure from routine is automatically harmful, and in some settings limited flexibility may serve a therapeutic purpose. However, the difficulty lies in the fact that boundaries are often not crossed in a single dramatic moment, but through gradual shifts that may become normalized over time. This "slippery slope" is particularly important in psychiatry, where the clinician's rescue fantasies, wish to be admired, curiosity, loneliness, countertransference vulnerabilities, or personal crises may subtly reshape judgment. In this field, harm is determined less by the psychiatrist's intention than by the meaning of the act for the patient and by its impact on the treatment frame.

Contemporary communication environments have made these questions even more complex. Messaging applications, online searching, social media visibility, and hybrid professional-public identities increasingly blur the line between the consulting room and the outside world. Digital communication does not suspend ethical obligations; rather, it extends classic boundary questions into new forms. This workshop approaches these themes from a different perspective: art. Instead of examining boundary dynamics solely through case presentations, the aim is to engage participants through spontaneity and creativity. Theory and subjectivity will be addressed together through group work with participants from diverse experience levels and clinical backgrounds. Academic and clinical discussions about boundaries will be explored through the provocative aspects of group dynamics and art.

References

1. American Psychiatric Association. The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry. Washington, DC: American Psychiatric Association; 2013.
2. Friedman SH, Martinez RP. Boundaries, professionalism, and malpractice in psychiatry. Focus (Am Psychiatr Publ) 2019;17:365-371.
3. Farnan JM, Snyder Sulmasy L, Worster BK, Chaudhry HJ, Rhyne JA, Arora VM. Online medical professionalism: patient and public relationships: policy statement from the American College of Physicians and the Federation of State Medical Boards. Ann Intern Med 2013;158:620-627.

What Does Psychotherapy Do in the Brain? Stories in the Brain

Şahabettin Çetin
Pamukkale University Faculty of Medicine, Department of Psychiatry, Denizli

Psychotherapy has historically been described as a verbal and relational practice of healing, yet contemporary neuroscience increasingly suggests that it is also a context for experience-dependent neuroplasticity. Rather than merely enabling a person to narrate life events, psychotherapy provides conditions in which affect, attention, memory, and interpersonal expectations can be reworked within a safer relational environment. Longitudinal neuroimaging studies indicate that psychotherapy is associated with functional changes in brain networks involved in emotion processing and regulation, particularly within prefrontal-limbic systems. This perspective allows psychotherapy to be understood not only as meaning-making, but also as a process of neural reorganization.

Memory is central to this account. Therapeutic change does not depend solely on the recall of explicit autobiographical memories; it also involves implicit, procedural, and affectively charged traces carried in bodily states, action tendencies, and repetitive relational patterns. Findings from reconsolidation research suggest that when emotionally salient memories are reactivated under new interpersonal and affective conditions, they may become modifiable. In psychotherapy, repeated encounters with previously feared, dissociated, or unmentalized experiences may therefore allow the updating of old emotional learning rather than the simple repetition of the past. Social cognition constitutes another major pathway of change. The capacity to understand one's own and others' mental states, commonly referred to as Theory of Mind (ToM), is closely linked to interpersonal regulation, empathy, and psychological flexibility. In parallel, the mirror neuron system has been proposed as part of the neural basis of embodied resonance with others' actions and affects. In psychodynamic and group settings, these capacities are mobilized through mutual attention, affective attunement, role responsiveness, and the recognition of self-other boundaries. Group processes may intensify such mechanisms by placing the person in a shared field of simultaneity, witnessing, and spontaneous interaction.

Finally, the body is not secondary to therapeutic change. Sensation, posture, gesture, movement, and autonomic arousal often carry aspects of experience that are not yet fully symbolized. Bringing these bodily elements into awareness may help connect implicit emotional experience with representation and language. This workshop aims to discuss what psychotherapy does in the brain through four interconnected themes—neuroplasticity,

memory systems, ToM and mirroring, and the contribution of body and movement—while keeping the clinical and experiential dimensions of group work at the center.

References

1. Aarts I, Thorsen AL, Vriend C, et al. (2024) Effects of psychotherapy on brain activation during negative emotional processing in patients with posttraumatic stress disorder: a systematic review and meta-analysis. Brain Imaging Behav 18(2):444-455.
2. Lane RD, Ryan L, Nadel L et al. (2015) Memory reconsolidation, emotional arousal, and the process of change in psychotherapy: New insights from brain science. Behav Brain Sci 38:e1.
3. Schurz M, Radua J, Aichhorn M et al. (2014) Fractionating theory of mind: A meta-analysis of functional brain imaging studies. Neurosci Biobehav Rev 42:9-34.

TMS in the Treatment of Depression: When, for Whom, and How?

Burç Çağrı Poyraz
Istanbul University-Cerrahpaşa, Cerrahpaşa Faculty of Medicine, Department of Psychiatry

Mood disorders, particularly major depressive disorder (MDD), remain among the leading contributors to the global burden of disease, and a substantial proportion of patients fail to achieve adequate clinical response despite standard pharmacotherapy and psychotherapy. In this context, neuromodulation-based approaches have attracted increasing interest in recent years, with transcranial magnetic stimulation (TMS) emerging as a non-invasive treatment option with demonstrated efficacy and safety in clinical practice (George et al., 2010).
Since its first application to the human brain in 1985, TMS has found therapeutic use in various psychiatric disorders, particularly treatment-resistant depression (TRD). With its integration into clinical practice, a range of stimulation parameters, frequency modulations, and coil designs have been developed to optimize treatment efficacy. These advancements aim not only to enhance symptomatic improvement but also to shorten treatment duration and improve patient adherence.
In this presentation, the clinical use of TMS in depression will be discussed within the framework of the key questions: “when, for whom, and how.” The operational definition of treatment resistance, appropriate patient selection, and clinical indications will be addressed, along with an evaluation of where TMS should be positioned within the treatment algorithm based on current guidelines. The neurobiological foundations of target cortical regions—particularly the dorsolateral prefrontal cortex (DLPFC)—and their relationship to mood regulation will also be reviewed.
In addition to conventional high-frequency left DLPFC and low-frequency right DLPFC protocols, more time-efficient approaches such as intermittent theta-burst stimulation (iTBS) and accelerated protocols (e.g., SAINT) will be discussed in terms of clinical efficacy and rapid remission potential. Notably, iTBS has been shown to provide comparable efficacy to standard protocols while significantly reducing application time, whereas accelerated protocols may yield rapid clinical responses in selected patient populations (Blumberger et al., 2021; Cole et al., 2022).
Furthermore, advances in coil technology have enabled the development of deep TMS approaches that can target medial and deeper brain structures, such as the anterior cingulate cortex, beyond superficial cortical areas, thereby potentially modulating treatment response. The integration of TMS with pharmacotherapy and psychotherapy, the impact of combined treatment approaches on clinical outcomes, and real-world data will also be considered.

Finally, the sustainability of acute treatment response will be addressed as a critical clinical issue. Current evidence on maintenance TMS and relapse prevention strategies will be discussed. Within this framework, the role of TMS in the treatment of depression will be evaluated through a comprehensive perspective informed by evidence-based data and clinical experience, with the aim of providing practical insights for clinical application.

References

1. George MS, Lisanby SH, Avery D, McDonald WM, Durkalski V, Pavlicova M, et al. Daily left prefrontal transcranial magnetic stimulation therapy for major depressive disorder: a sham-controlled randomized trial. Arch Gen Psychiatry. 2010 May;67(5):507–16.
2. Blumberger DM, Vila-Rodriguez F, Wang W, Knyahnytska Y, Butterfield M, Noda Y, et al. A randomized sham controlled comparison of once vs twice-daily intermittent theta burst stimulation in depression: A Canadian rTMS treatment and biomarker network in depression (CARTBIND) study. Brain Stimul. 2021 Dec;14(6):1447–55.
3. Cole EJ, Phillips AL, Bentzley BS, Stimpson KH, Nejad R, Barmak F, et al. Stanford Neuromodulation Therapy (SNT): A Double-Blind Randomized Controlled Trial. Am J Psychiatry. 2022 Feb;179(2):132–41.

Procedural and Scientific Appropriateness

İbrahim Erdi Gılçık
Adana City Training and Research Hospital

A medical report is a written document prepared by a physician or a board of physicians that presents the evaluation of an individual's physical or mental health status. Through this report, the clinician communicates their professional conclusion to an authorized person or institution. Only physicians are legally authorized to issue such reports, and this responsibility carries both clinical and legal implications. The principles and procedures regarding medical reports were defined by the Ministry of Health in its directive dated 02.05.2017, covering various types such as disability board reports, driver's license reports, firearm license evaluations, medication reports, and sick leave reports.
In clinical practice, requests for sick leave reports frequently place psychiatrists in a dilemma. Decisions based on cross-sectional evaluations may be vulnerable to misuse, including manipulative or simulative behaviors, as well as treatment non-adherence. Additionally, heavy workloads may limit clinicians' ability to fully recognize these situations, potentially leading to unnecessarily prolonged reports. In cases where there is doubt about medical validity, patients are referred to designated arbitration hospitals. In such evaluations, it is often observed that patients lack regular psychiatric follow-up, are not using psychotropic medication, and have no documented psychotherapeutic intervention. The aim is to emphasize the importance of objective, consistent, and well-documented clinical assessment.

Assessment of Functionality and Dependency in Medical Board Reports
Medical board reports do not only define a diagnosis but also evaluate how that diagnosis affects an individual's daily life, functioning, and level of dependency. These reports play a crucial role in disability determination, incapacity for work, and legal processes. Therefore, the primary determinant is not the diagnosis itself, but the degree of functional impairment. Psychiatric functional assessment is multidimensional, including activities of daily living, social functioning, occupational/academic performance, and cognitive capacity. This evaluation is based on clinical observation, patient and caregiver information, and standardized tools. GAF assesses both symptom severity and functioning, whereas SOFAS focuses solely on social and occupational functioning, often providing a clearer picture of disability. WHODAS 2.0 offers a comprehensive and standardized evaluation across multiple domains, including cognition, self-care, social participation, and daily activities.

A decline in functionality directly determines the level of dependency. Dependency reflects the extent to which an individual requires support to maintain daily life rather than the severity of illness alone. It is evaluated across three domains: basic self-care, instrumental activities of daily living, and the need for supervision and safety. Ultimately, medical board decisions should be based on this comprehensive framework, aiming not only to determine eligibility for rights and benefits but also to ensure patient safety and well-being.

In this presentation, we aimed to highlight and systematically explore the assessment of functionality and dependency, emphasizing the importance of focusing on real-life functioning rather than diagnosis alone in medical board evaluations.

References

1. Psychometric properties of world health organization disability assessment schedule 2.0 (WHODAS 2.0) disability scores in Turkish psychiatry patients
2. Psikiyatride Rapor Düzenleme Kılavuzu 2. Baskı s. 159
3. https://www.resmigazete.gov.tr/eskiler/2013/03/20130330-4.htm

From One End to the Other: The Relationship Between Mood and Emotion in Bipolar Disorder

Kürşat Altınbaş

Bipolar disorder (BD) is traditionally defined by recurrent episodes of mania, hypomania, and depression; however, accumulating evidence suggests that disturbances in emotion regulation extend far beyond episodic mood changes and may represent a core, trait-like feature of the disorder. Emotion regulation difficulties (ERD) are increasingly recognized not only during acute affective episodes but also during euthymic periods, indicating a more pervasive dysfunction that may underlie vulnerability to relapse and functional impairment.

Individuals with BD tend to rely more frequently on maladaptive emotion regulation strategies (ERS), including rumination, self-blame, avoidance, and risk-taking behaviors. These strategies often amplify emotional reactivity and contribute to the persistence and severity of both depressive and (hypo)manic symptoms. In contrast, adaptive strategies such as cognitive reappraisal, acceptance, and problem-solving appear to be less effectively utilized. This imbalance between maladaptive and adaptive ERS may partly explain the fluctuations in mood and the difficulty in maintaining emotional stability even in the absence of full-blown episodes.

Importantly, ERD has also emerged as a potentially valuable construct in the differential diagnosis of BD. Compared to other psychiatric conditions, such as major depressive disorder or certain personality disorders, individuals with BD may exhibit distinct patterns of emotional reactivity, regulation failures, and social cognitive processing. These differences highlight the relevance of examining emotion regulation not only as a symptom dimension but also as a transdiagnostic and potentially endophenotypic marker.

Despite growing interest in this field, methodological challenges remain. Much of the current evidence relies on self-report measures, which are limited by recall bias and subjective interpretation. Consequently, there is a growing shift toward more objective and ecologically valid assessment methods, including ecological momentary assessment (EMA), digital phenotyping, and biomarker-based approaches. These innovations allow for real-time tracking of mood and emotional dynamics, offering a more nuanced understanding of how emotion regulation unfolds in daily life.

From a clinical perspective, addressing ERD in BD requires an integrative and personalized approach. Pharmacological treatments remain essential for mood stabilization, but should be complemented by psychotherapeutic interventions targeting emotion regulation, such as cognitive behavioral therapy, mindfulness-based approaches, and emotion-focused therapies. Additionally, digital tools and lifestyle-based strategies, including sleep regulation and stress management, may further enhance treatment outcomes.

In conclusion, exploring the relationship between mood and emotion “from one end to the other” provides a comprehensive framework for understanding BD. This perspective not only refines diagnostic clarity but also opens new avenues for targeted and individualized interventions.

The Trace Left in the Brain: Trauma and Neural Reorganization

Sena Ece Ilgın
Marmara University Pendik Training and Research Hospital, Department of Psychiatry; PhD Student in Neuroscience, Yeditepe University

Trauma is not merely a psychological experience but a neurobiological process that profoundly affects brain functioning and emotional regulation. Contemporary neuroscientific research indicates that traumatic experiences disrupt the functional balance among key brain regions, particularly the amygdala, hippocampus, and prefrontal cortex. In individuals exposed to trauma, brain regions associated with threat detection show increased activation, whereas prefrontal areas responsible for cognitive control and emotional regulation tend to exhibit reduced activity. This imbalance contributes to commonly observed post-traumatic symptoms, including heightened vigilance, intrusive re-experiencing, and emotional numbing (Cao et al. 2025).

The amygdala plays a central role in detecting and responding to perceived threats, often becoming hyperresponsive following trauma exposure. In contrast, the prefrontal cortex, which is essential for top-down regulation of emotional responses, may show diminished regulatory capacity. The hippocampus, involved in memory processing and contextualization, can also be affected, leading to fragmented or intrusive memory experiences. These neurobiological alterations highlight that trauma-related symptoms are not solely psychological in nature but are closely linked to measurable changes in brain function.

At the same time, evidence from neuroscience emphasizes the brain's capacity for neuroplasticity, defined as the ability of neural systems to reorganize structurally and functionally in response to experience. Trauma-focused psychotherapeutic interventions have been shown to facilitate this adaptive reorganization. For example, Schlumpf et al. (2019) demonstrated that psychotherapy targeting trauma is associated with significant functional changes in neural networks involved in emotional regulation. Strengthened connectivity between the prefrontal cortex and limbic regions appears to support more effective regulation of emotional responses.

These findings suggest that recovery from trauma is not based on the elimination of traumatic memories but rather on the brain's ability to reorganize and integrate these experiences in a more adaptive manner. Understanding trauma within a neuroscientific framework provides a valuable perspective for clinical practice, as it supports the development of targeted, evidence-based interventions while also reducing stigma by framing trauma-related symptoms within a

biological context. Such an approach may contribute to more compassionate and inclusive mental health care.

References

1. Cao M, Zhu S, Tang E, Xue C, Li K, Yu H, Zhong T, Li T, Chen H, Deng W (2025) Neural correlates of emotional processing in trauma-related narratives. Psychological Medicine 55:e33.
2. Schlumpf YR, Nijenhuis ERS, Klein C, Jäncke L, Bachmann S (2019) Functional reorganization of neural networks involved in emotion regulation following trauma therapy for complex trauma disorders. NeuroImage Clin 23:101807.

Borderline Representations in Music

Onur Özel
Kanuni Sultan Süleyman Training and Research Hospital

Music, as one of the most direct forms of artistic expression, provides a powerful medium for reflecting the core phenomena observed in borderline personality organization. According to Kernberg, the borderline level of personality organization lies between neurotic and psychotic levels. At this level, primitive defense mechanisms may become prominent, and although there may be transient disturbances in reality testing, a complete loss of reality is not expected. Emotions are experienced with greater intensity and are often difficult to regulate. In music, we can often see patterns that reflect aspects of borderline personality organization. These representations should not be understood merely as reflections of clinical pathology in art, but rather as intensified expressions of universal human emotional experience.
As illustrated in different musical examples, Teoman's Serseri reflects emotional instability, identity confusion, and a tension between the need for connection and the impulse to withdraw. It also conveys a perception of the world as unreliable and unsafe, which may be understood as a defense against vulnerability and fears of abandonment. Similarly, Model's Makyaj highlights themes of unstable self-image and externalized identity, while also reflecting difficulty tolerating separation and the idealization of the lost object. The emotional intensity of this process is accompanied by a decline in functioning, emphasizing the impact of affective dysregulation on everyday life. Musa Eroğlu's Mihriban presents a more enduring yet idealized emotional experience; the intensity and absolutist nature of love, which appears to underlie this state, can be understood as echoing borderline patterns of idealization and difficulty in integrating loss.
In this presentation, we examined themes in music that evoke borderline personality organization through a psychiatric lens within an artistic context.

References

1. Yeomans, Frank E.; Clarkin, John F.; Kernberg, Otto F.
Borderline Kişilik Bozukluğu İçin Aktarım Odaklı Psikoterapi: Klinik Bir Rehber.
İstanbul: Psikoterapi Enstitüsü, 2017.

Neurobiology of Stress: Implications for Psychiatric Prevention and Treatment

Christiaan H. Vinkers
Department of Psychiatry, Amsterdam UMC, Vrije Universiteit Amsterdam, Amsterdam Neuroscience, Amsterdam, the Netherlands

Stress is not inherently harmful. It is an adaptive response that mobilizes biological and psychological resources when environmental demands change. Whether stress promotes adaptation or contributes to psychiatric symptoms depends less on a single level of activation than on its timing, context, controllability, and recovery. Large interindividual differences in appraisal, coping, biological reactivity, and environmental resources therefore shape the transition from health to disorder.

The stress response operates across interacting molecular, neuroendocrine, autonomic, immune, neural, cognitive, and behavioural systems. Cortisol illustrates why static biomarkers are insufficient. Its effects depend on circadian and ultradian rhythms, the timing of exposure, mineralocorticoid and glucocorticoid receptor signalling, previous experience, and the functional state of target tissues.[1] In major depressive disorder and posttraumatic stress disorder, group level differences in cortisol have been reported, but findings are heterogeneous and currently lack adequate diagnostic precision. Progress will require repeated measurements in daily life, assessment of receptor sensitivity, and identification of biologically meaningful subgroups rather than assuming a uniform cortisol abnormality.

Childhood trauma provides an important example of how prolonged stress exposure may alter later vulnerability. It is common across psychiatric disorders and is associated with persistent affective symptoms, altered stress sensitivity, behavioural and metabolic risk, and changes across multiple biological systems. However, childhood trauma should not be interpreted as therapeutic determinism. Although patients with depression and childhood trauma generally enter treatment with greater symptom severity, meta analytic evidence indicates that they can benefit substantially from established pharmacological and psychological treatments.[2] Recognition of childhood trauma should therefore inform clinical formulation and, where relevant, treatment adaptation, but should not delay access to evidence based care.

Resilience is likewise better understood as a dynamic outcome than as a fixed personal trait. Resilience factors, such as social support and self efficacy, predict favourable outcomes, whereas resilience mechanisms are the processes activated during adversity, including flexible appraisal, emotion regulation, and goal directed behaviour.[3] These mechanisms are embedded in social and organisational contexts. Prevention should therefore combine early

detection of failing recovery with interventions that strengthen adaptive processes and reduce avoidable environmental stressors.

A clinically useful neurobiology of stress must move beyond isolated measurements and simple notions of too much or too little stress. The central challenge is to characterize when, in whom, and under which conditions stress responses remain flexible or become maladaptive, and to translate this knowledge into better timed, stratified, and context sensitive prevention and treatment.

References

1. Joëls M, Baram TZ. The neuro-symphony of stress. Nature Reviews Neuroscience. 2009;10(6):459–466. doi:10.1038/nrn2632.
2. Childhood Trauma Meta-Analysis Study Group. Treatment efficacy and effectiveness in adults with major depressive disorder and childhood trauma history: a systematic review and meta-analysis. The Lancet Psychiatry. 2022;9(11):860–873. doi:10.1016/S2215-0366(22)00227-9.
3. Kalisch R, Russo SJ, Müller MB. Neurobiology and systems biology of stress resilience. Physiological Reviews. 2024;104(3):1205–1263. doi:10.1152/physrev.00042.2023.

Values and Norms: What Does Moral Philosophy Tell Psychiatry?

Merve Cura
Child and Adolescent Psychiatrist, Private Practice, Ankara, Türkiye

Psychiatry is situated at a distinctive intersection between scientific description and normative judgment. Diagnostic systems aim to identify patterns of distress, dysfunction, and risk; yet clinical decisions also imply judgments about autonomy, rationality, well-being, social adaptation, and the kind of life considered worth restoring. For this reason, psychiatry cannot remain ethically neutral. Every diagnosis and intervention raises an implicit question: whose conception of the good is being protected, and whose norm is being applied?

This presentation examines the contribution of major traditions in moral philosophy to psychiatric practice. Kantian ethics offers a foundational account of dignity and autonomy through the injunction to treat persons always as ends in themselves, never merely as means. In psychiatry, this principle challenges paternalism, coercive intervention, and the reduction of the patient to a diagnostic object. However, the clinical significance of autonomy becomes complex when decision-making capacity, severe distress, or risk is impaired.

Utilitarianism, particularly in John Stuart Mill, shifts attention from intention to consequences and collective welfare. It is highly relevant to decisions involving hospitalization, risk management, resource allocation, and social functioning. Yet it also generates a central psychiatric dilemma: whose happiness or welfare is being maximized—the patient's, the family's, the institution's, or society's? A treatment that increases social conformity may not necessarily promote the patient's own flourishing.

Foucault's analyses of knowledge and power reveal how psychiatric classifications may function not only as descriptions but also as instruments of normalization. Clinical knowledge can become epistemically violent when it silences the patient's account and converts difference into pathology. Levinas provides a contrasting ethical orientation: the encounter with the face of the Other precedes theoretical mastery and calls the clinician to responsibility for an irreducibly different subject. From this perspective, listening is not merely a clinical technique but an ethical act.

The presentation concludes with virtue ethics and the model developed by Jennifer Radden and John Z. Sadler in The Virtuous Psychiatrist. Principle-based ethics can identify duties and limits, but it cannot fully determine how a psychiatrist should perceive, deliberate, and respond in singular situations. Psychiatric practice therefore also requires character: practical wisdom, humility, empathy, patience, integrity, self-scrutiny, and sensitivity to boundaries and power.

Moral philosophy does not provide psychiatry with a final algorithm. It offers a disciplined way of asking better questions. Ethical psychiatric practice begins when the clinician moves beyond the question “What is normal?” and asks, together with the patient, “What would constitute a good and livable life for this person?”

Keywords: psychiatry, moral philosophy, autonomy, normalization, virtue ethics

References

1. Aristotle. (2014). Nicomachean ethics (R. Crisp, Ed. & Trans.; 2nd ed.). Cambridge University Press.
2. Beauchamp, T. L., & Childress, J. F. (2019). Principles of biomedical ethics (8th ed.). Oxford University Press.
3. Foucault, M. (1988). Madness and civilization: A history of insanity in the Age of Reason (R. Howard, Trans.). Vintage Books.
4. Kant, I. (2012). Groundwork of the metaphysics of morals (M. Gregor & J. Timmermann, Eds. & Trans.). Cambridge University Press.
5. Levinas, E. (1969). Totality and infinity: An essay on exteriority (A. Lingis, Trans.). Duquesne University Press.
6. Mill, J. S. (2001). Utilitarianism (G. Sher, Ed.). Hackett Publishing Company.
7. Radden, J., & Sadler, J. Z. (2009). The virtuous psychiatrist: Character ethics in psychiatric practice. Oxford University Press.

The Psychological Impact of the Nagorno-Karabakh War: Past, Present, and Future

Elmir Tahmazov

War is a man-made trauma that affects large populations, and numerous studies have focused on its psychological impact on individuals. Between 1945 and 1992, 149 major wars occurred, causing the deaths of more than 23 million people. Individuals exposed to war have sometimes been forced to migrate from their own countries to another, or have begun living in a new place as refugees, leading to various issues, primarily socioeconomic and psychological problems. Various eating disorders, infectious diseases, injuries due to physical violence, sexual abuse, chronic illnesses, and psychological disorders such as depression, anxiety, adjustment disorder, and post-traumatic stress disorder (PTSD) can be observed in war victims. While Armenia, which held the Nagorno-Karabakh region and its surroundings under occupation for approximately 30 years, rejected all proposals for a peaceful resolution to the conflict, the counter-offensive launched by the Azerbaijani army in September 2020 against Armenian attacks continued for 44 days, from September 27 to November 10, 2020. Suffering a major defeat in this war, the Armenian army ultimately accepted surrender in accordance with the trilateral statement signed by Russia, Azerbaijan, and Armenia, and withdrew from Azerbaijani territories. Upon the invitation of the Ministry of Emergency Situations, starting from January 2021, free psychological assistance was provided with the joint participation of professional psychotherapists from the brotherly country and psychologists from the Ministry of Emergency Situations. During this period, approximately 9,500 psychological assistance sessions were provided to nearly 4,000 citizens in various regions of the republic, including up to 430 children and adolescents. In the first days of the 2020 Nagorno-Karabakh war, the Association of Azerbaijani Physicians sent approximately 70 volunteer doctors, who were receiving medical residency training or working as physicians in Turkey, to Azerbaijan. Out of the 70 doctors who went to the war zone, 56 individuals who agreed to participate formed our case group. The control group included 56 Azerbaijani physicians who were either receiving medical residency training or working as physicians in Turkey. Consequently, 112 individuals who provided online consent to participate voluntarily were included in our study. Wars have persisted throughout all periods of history, while technological advancements have altered the format of warfare. PTSD, major depression, anxiety disorder, and other psychological disorders rank among the leading conditions causing disability. The results of this study demonstrate that psychological problems, particularly PTSD, are prevalent among Azerbaijani civilian doctors who were exposed to war trauma, despite working far from the war zone in a safe environment (Turkey). Contrary to common belief, our study is significant in showing that war causes long-lasting

psychological disorders not only in military personnel but also in civilians, and that these disorders persist even after individuals leave the war environment and return to work in another country.

Suicide Risk Among Physicians: Profession-Specific Factors and Clinical Approach

Gülin Özdamar Ünal
Department of Psychiatry, Süleyman Demirel University Faculty of Medicine

Suicide is a complex and dynamic phenomenon resulting from the interaction of biological, psychological, and social factors and cannot be attributed to a single cause. Throughout their professional careers, psychiatrists frequently encounter patients experiencing suicidal ideation, suicide attempts, or death by suicide. However, the loss of a colleague to suicide represents a unique clinical and emotional burden. This presentation addresses profession-specific risk factors for suicide among physicians, summarizes current epidemiological evidence, and reviews key principles of clinical assessment and management.

Compared with the general population, physicians have an approximately 40–45% higher risk of death by suicide. This increased vulnerability begins during medical education. A meta-analysis including approximately 122,000 medical students reported a prevalence of depression of 27.2% and suicidal ideation of 11.1%. Despite these alarming rates, only 15.7% of students with depression sought professional mental health care. Academic pressure, perfectionism, intense competition, long working hours, sleep deprivation, and stigma associated with help-seeking constitute the major risk factors during this period. Rather than diminishing after graduation, these risks often intensify during residency and early specialist training, when increasing workload, professional identity transition, and burnout further contribute to psychological distress. In particular, physicians working more than 55 hours per week demonstrate significantly higher rates of suicidal ideation.

Untreated depression, burnout, maladaptive perfectionism, imposter syndrome, and excessive identification of personal worth with professional identity represent important individual risk factors. In addition, physicians face several occupation-specific vulnerabilities, including easy access to lethal medications, a tendency toward self-treatment, repeated exposure to patient deaths, the "second victim" phenomenon following medical errors, loss of professional autonomy, excessive administrative burden, and reluctance to seek psychiatric care because of stigma. Suicide risk appears to be particularly elevated in specialties such as psychiatry and anesthesiology. Among psychiatrists, repeated exposure to patient suicide, accompanied by persistent feelings of grief, responsibility, and guilt, constitutes an additional occupational hazard.

During clinical assessment, clinicians should recognize that physician-patients may minimize or conceal suicide risk. Suicidal thoughts, intent, planning, method, and timing should therefore be explored through direct and comprehensive questioning, and access to lethal means must be

carefully evaluated. Although standardized suicide risk assessment instruments may provide supportive information, they should never replace comprehensive clinical judgment. Evidence-based interventions include pharmacological treatments such as lithium, clozapine, ketamine/esketamine, and antidepressants when clinically indicated, together with safety planning, cognitive behavioral therapy, and dialectical behavior therapy. For physician-patients, treatment should ideally be conducted by an independent psychiatrist, with strict protection of confidentiality, avoidance of self-prescribing practices, and explicit consideration of concerns related to professional identity and career implications.

Physician suicide should not be viewed as an expression of individual weakness but rather as a preventable public health problem arising from the interaction between personal vulnerabilities and occupational as well as systemic pressures. Regular mental health screening beginning in medical school, anti-stigma initiatives, confidential support services, and early intervention programs are essential strategies that can protect physicians' well-being while simultaneously improving the quality and safety of healthcare delivery.

References

1. Rotenstein, L. S., Ramos, M. A., Torre, M., Segal, J. B., Peluso, M. J., Guille, C., Sen, S., & Mata, D. A. (2016). Prevalence of Depression, Depressive Symptoms, and Suicidal Ideation Among Medical Students: A Systematic Review and Meta-Analysis. JAMA, 316(21), 2214–2236. https://doi.org/10.1001/jama.2016.17324
2. Dyrbye LN, Burke SE, Hardeman RR, et al. Association of clinical specialty with symptoms of burnout and career choice regret among US resident physicians. JAMA. 2018;320:1114–1130.
3. Shanafelt TD, West CP, Sinsky C, et al. Changes in burnout and satisfaction with work-life integration in physicians and the general US working population between 2011 and 2017. Mayo Clin Proc. 2019;94:1681–1694.

Systemic and Relational Dynamics in Vaginismus: Family Structure, Couple Interaction, and Attachment Patterns

Gülin Özdamar Ünal
Department of Psychiatry, Süleyman Demirel University Faculty of Medicine

Although vaginismus was traditionally conceptualized as a sexual dysfunction characterized primarily by involuntary contraction of the vaginal muscles, it is now understood within the biopsychosocial framework as a complex clinical condition involving the interaction of biological, psychological, relational, and sociocultural factors. The integration of vaginismus and dyspareunia under the diagnosis of Genito-Pelvic Pain/Penetration Disorder (GPPPD) in both the DSM-5 and ICD-11 reflects a shift from a purely muscular explanation toward a more comprehensive model encompassing pain, fear, anxiety, and pelvic floor muscle hypertonicity. Nevertheless, the term vaginismus continues to be widely used in clinical practice because of its descriptive and practical value.

Beyond being an individual symptom, vaginismus should be understood within the broader context of family systems, intimate relationships, and attachment processes. From the perspective of systemic family therapy, symptoms are not solely individual phenomena but may represent embodied expressions of unresolved tensions and dysfunctional interaction patterns within the family system. Bowen's Family Systems Theory offers a valuable framework for understanding vaginismus through concepts such as differentiation of self, multigenerational transmission, triangulation, and emotional cutoff. Low levels of self-differentiation, excessive emotional fusion in the mother–daughter relationship, and the intergenerational transmission of fear and anxiety regarding sexuality may contribute to the development of protective bodily responses. From this perspective, involuntary vaginal contraction may be interpreted not merely as a physiological reflex but also as a somatic mechanism for maintaining psychological boundaries.

Minuchin's Structural Family Therapy further emphasizes the role of family boundaries and subsystem organization in the development and maintenance of vaginismus. In families where the marital subsystem fails to establish sufficient autonomy and members of the extended family—particularly mothers or mothers-in-law—become excessively involved in the couple's relationship, personal boundaries and intimacy may be compromised. Cross-generational coalitions, diffuse boundaries, and disturbances in family power hierarchies can perpetuate the symptom. Under these circumstances, vaginismus may function not only as avoidance of penetration but also as a systemic strategy for preserving relational boundaries within the family structure.

Attachment Theory, originally proposed by Bowlby, provides another important perspective. Early caregiver relationships shape an individual's expectations regarding trust, intimacy, emotional security, and bodily experiences in adult relationships. Secure attachment appears to serve as a protective factor for healthy sexual functioning, whereas anxious, avoidant, and particularly disorganized attachment styles may lead individuals to perceive intimacy as simultaneously desired and threatening. This internal conflict may manifest physically through involuntary muscle contraction, avoidance behaviors, and fear of penetration. Accordingly, vaginismus can be conceptualized as the somatic expression of a situation in which the mind desires intimacy while the body interprets it as a threat.

In conclusion, vaginismus should not be regarded solely as a sexual dysfunction but rather as a multidimensional clinical condition reflecting an individual's attachment history, family system dynamics, and the quality of emotional security within the couple's relationship. Effective treatment therefore requires more than symptom reduction. A comprehensive therapeutic approach should include restructuring dysfunctional family boundaries, strengthening the couple's relationship, fostering secure attachment, and, when appropriate, integrating systemic family therapy with couple therapy. Understanding vaginismus as the language of relationships and family systems, rather than merely as an individual's symptom, may facilitate more sustainable and enduring treatment outcomes.

References

1. Ait Souabni, S., Prasad, S., Ahmed, F., & Belhaddad, E. H. (2023). The Importance of Sociocultural Factors for Understanding and Managing Genito-Pelvic Pain/Penetration Disorder: The Example of Muslim Societies. The Journal of nervous and mental disease, 211(4), 327–333.
2. Dias-Amaral, A., & Marques-Pinto, A. (2018). Female Genito-Pelvic Pain/Penetration Disorder: Review of the Related Factors and Overall Approach. Perturbação de dor Gênito-pélvica e da penetração: revisão dos fatores associados e abordagem geral. Revista brasileira de ginecologia e obstetricia : revista da Federacao Brasileira das Sociedades de Ginecologia e Obstetricia, 40(12), 787–793. https://doi.org/10.1055/s-0038-1675805.
3. Banaei, M., Mehrnoush, V., Roozbeh, N., & Kariman, N. (2023). Coping Strategies with Genito-Pelvic Pain/Penetration Disorder: A Qualitative Study. Pain research & management, 2023, 5791751. https://doi.org/10.1155/2023/5791751

Neurobiological and Clinical Characteristics of Adult ADHD: What Should We Know and How Should We Conduct the Diagnostic Assessment?

Bengi Semerci
Bengi Semerci Institute

Attention-Deficit/Hyperactivity Disorder (ADHD) is defined as a neurodevelopmental disorder characterized by persistent patterns of inattention and/or hyperactivity–impulsivity that directly interfere with academic, occupational, or social functioning (DSM-5, American Psychiatric Association, 2013).

ADHD begins in childhood and persists into adulthood in approximately 65–70% of cases. Epidemiological studies estimate its prevalence to be around 5% in children and approximately 2.5% in adults.

The diagnostic assessment of adult ADHD is based on a comprehensive clinical evaluation, including self-reported symptoms, a detailed developmental history covering both childhood and adulthood, and a structured clinical interview. Whenever possible, collateral information obtained from parents, spouses, or other close relatives significantly contributes to diagnostic accuracy. According to DSM-5 criteria, individuals aged 17 years and older must exhibit at least five symptoms of inattention and/or hyperactivity-impulsivity to meet the diagnostic threshold. Executive function impairments—including difficulties in planning, organization, time management, behavioral regulation—as well as emotional dysregulation are important clinical features that support the diagnosis (Kooij et al., 2019).

Semi-structured diagnostic interviews may be used during the clinical assessment to facilitate diagnosis and identify psychiatric comorbidities. The Turkish versions of ACE+ and DIVA 2.0 are available and widely used for this purpose.

ADHD remains a clinical and behavioral diagnosis. Rating scales used in ADHD assessment are subjective screening instruments that evaluate symptoms and functional impairment over a defined period of time. Therefore, they are not diagnostic by themselves but rather supportive tools. Validated Turkish instruments include the Wender Utah Rating Scale (WURS), Current Symptoms Scale (CSS), and the Adult ADHD Self-Report Scale (ASRS-v1.1).

Neuropsychological tests are not diagnostic for ADHD. However, they provide valuable information regarding an individual's cognitive strengths and weaknesses and may help identify developmental, behavioral, and psychiatric comorbidities. Consequently, these assessments contribute to the development of individualized treatment plans (Kooij et al., 2019).

During the diagnostic evaluation, clinicians should systematically assess psychiatric and medical conditions that may mimic ADHD symptoms or coexist with ADHD. A detailed personal and

family history of neurological and physical illnesses should also be obtained. Since treatment priorities largely depend on the presence and severity of comorbid conditions, their assessment constitutes an essential component of the diagnostic process (Jacob et al., 2007).
In conclusion, the diagnosis of adult ADHD requires a comprehensive clinical assessment that includes developmental history, current functioning, family history, previous and current psychiatric and medical conditions, and medication history. Accurate diagnosis depends on integrating information from multiple sources rather than relying on rating scales or neuropsychological testing alone.

References

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (5th ed.). Washington, DC: APA; 2013.
2. Jacob CP, Romanos J, Dempfle A, et al. Co-morbidity of adult attention-deficit/hyperactivity disorder with focus on personality traits and related disorders in a tertiary referral center. European Archives of Psychiatry and Clinical Neuroscience. 2007;257(6):309–317.
3. Kooij JJS, Bijlenga D, Salerno L, et al. Updated European Consensus Statement on diagnosis and treatment of adult ADHD. European Psychiatry. 2019;56:14–34.

ADHD in the Workplace: Executive Dysfunction, Performance Pressure, and the Cycle of Burnout

Bengi Semerci
Bengi Semerci Institute

Research has consistently shown that individuals with ADHD experience poorer educational and occupational outcomes than their peers. They are more likely to repeat school years, drop out of school, work in lower-skilled occupations, experience unemployment, change jobs frequently, and report lower job satisfaction (Barkley, 2002).

ADHD has a direct impact on occupational performance. Performance is measurable, and employers expect employees to maintain high levels of productivity. Many core symptoms of ADHD interfere with these expectations. Adults with ADHD often experience adverse work outcomes due to impairments in executive functioning. The continuous pressure to maintain adequate performance, combined with executive function deficits, places these individuals at increased risk for occupational burnout. Burnout is characterized by chronic physical, mental, and emotional exhaustion resulting from the continuous effort required to compensate for difficulties in planning, sustaining attention, emotional regulation, organization, and time management (Biederman et al., 2006).

The primary mechanisms underlying ADHD-related burnout include executive dysfunction and persistent performance pressure.

Continuous Executive Function Demands

Because of executive function impairments, adults with ADHD must invest substantially greater cognitive effort than their peers to complete routine occupational tasks. Maintaining attention, organizing information, initiating tasks, and monitoring performance require continuous self-regulation, resulting in increased mental fatigue.

Overcommitment, Impulsivity, and Hyperfocus

Individuals with ADHD frequently take on excessive responsibilities due to impulsivity, enthusiasm, and periods of hyperfocus. Initially, hyperfocus may result in exceptionally high productivity. However, as novelty decreases, motivation often declines, leading to difficulties in sustaining attention, planning, prioritizing tasks, and completing work efficiently. This pattern substantially contributes to burnout.

Emotional Dysregulation

Adults with ADHD often experience emotions more intensely than others. Feelings of frustration, disappointment, rejection, and perceived failure may accumulate over time. Without effective coping strategies, emotional dysregulation increases psychological stress and further accelerates burnout.

Work-Life Imbalance

Many adults with ADHD compensate for their symptoms by investing significantly more time and effort in their work than their colleagues. Although this compensation may temporarily improve performance, it often reduces the time available for personal relationships, leisure activities, and self-care, ultimately disrupting work-life balance and increasing the risk of burnout.

One of the most important protective factors against burnout is social support. Support should not be limited to professional interventions; encouragement and understanding from family members, friends, and the workplace play a crucial role in reducing stress and promoting long-term occupational well-being (Turjeman-Levi et al., 2024).

References

1. Barkley RA. Major life activity and health outcomes associated with attention-deficit/hyperactivity disorder. Journal of Clinical Psychiatry. 2002;63(Suppl 12):10–15.
2. Biederman J, Petty CR, Fried R, et al. Impact of psychometrically defined deficits of executive functioning in adults with attention-deficit/hyperactivity disorder. American Journal of Psychiatry. 2006;163:1730–1738.
3. Turjeman-Levi Y, Itzchakov G, Engel-Yeger B. Executive function deficits mediate the relationship between employees' ADHD and job burnout. AIMS Public Health. 2024;11(1):294–314.

Socıal And Socıetal Impacts Of Medıcal Cannabıs Use And Recommendations

Bilge BiLGiN KAPUCU

Cannabis is one of the most widely used drugs in the world. Its usage is increasing globally by the legalization processes. Medical cannabis may be beneficial for some types of epilepsies, chemotherapy-induced nausea or vomiting, HIV-induced cachexia, and some neurodegenerative diseases. However, it has been observed that usage increases as accessibility increases. Since these legalization processes are relatively new, long-term data is not yet available; however, an increase in use is observed in the countries that have legalized it. This increase is accompanied by data suggesting a rise in the hospital admissions due to cannabis-related causes. Although the data is not very reliable, an increase has been observed in some events of public concern, such as car accidents. Therefore, legalization policies should be limited to medical cannabis, and strict regulations on its use would be safe for our society.

References

1. Hall W, Stjepanović D, Dawson D, Leung J. The implementation and public health impacts of cannabis legalization in Canada: a systematic review. Addiction. 2023 Nov;118(11):2062-2072.
2. Zvonarev V, Fatuki TA, Tregubenko P. The Public Health Concerns of Marijuana Legalization: An Overview of Current Trends. Cureus. 2019 Sep 30;11(9):e5806.

Guardianship and Legal Capacity Assessments in Clinical Practice: Challenges and Perspectives

Yasin Hasan Balcıoğlu, Fatih Öncü
Bakirkoy Prof. Dr. Mazhar Osman Training and Research Hospital for Psychiatry, Neurology and Neurosurgery

Guardianship and legal capacity assessments have become an increasingly prominent area within psychiatric practice in Türkiye in recent years. Within the framework of Articles 405, 406, 408, and 429 of the Turkish Civil Code, the evaluation of an individual's legal capacity requires a multidimensional approach, taking into account conditions such as mental illness, intellectual disability, substance use disorders, prodigality, aging, and physical illness. In parallel with the growing number of applications to notary services, particularly among the geriatric population, there has been a marked increase in referrals for capacity evaluations. Situated at the intersection of psychiatry and civil law, these assessments extend beyond purely clinical evaluation. They constitute a critical forensic responsibility that directly impacts the protection of individual rights, the support of autonomy, and the prevention of unnecessary restrictions. Guardianship, as defined in the Turkish Civil Code, is a legal mechanism aimed at protecting individuals who are unable to manage their affairs, require continuous care, or pose a risk to themselves or others. While Article 405 addresses mental illness and intellectual disability, Article 406 includes conditions such as prodigality, addiction, and maladaptive lifestyle; Article 408 allows for voluntary restriction upon individual request; and Article 429 introduces legal counselling as a less restrictive alternative to full guardianship. In clinical practice, however, the application of these provisions often relies on case-specific judgment rather than standardized algorithms. Field experience suggests that psychiatrists frequently encounter challenges in these evaluations, including ambiguity in role boundaries, overlap with other medical specialties, and uncertainty regarding the scope and limits of assessment. These challenges highlight the need for a more structured and shared framework of practice.
This "Meet the Expert" session aims to explore current challenges and variations in guardianship and legal capacity assessments, focusing on the interface between clinical and legal domains. The session is designed as an interactive discussion, encouraging participant engagement and the use of real-life cases. Key topics include the preparation of medical board reports, clinical assessment of decision-making capacity, retrospective evaluations of legal capacity, determination of guardianship needs in cases involving addiction and aging, clarification of boundaries between guardianship and legal counselling, and strengthening communication between courts and healthcare institutions. In addition, the session will

address the importance of prioritizing less restrictive alternatives whenever possible, maintaining the balance between individual autonomy and public safety, and clarifying physicians' ethical and professional responsibilities. Common pitfalls in practice, documentation standards, and the practical implications of legislation will also be discussed through case-based examples. Beyond summarizing legal provisions, the session seeks to foster a shared clinical language and contribute to the development of a more standardized, ethical, and rights-based approach to guardianship practices.

References

1. Balcıoğlu YH, Öncü F. Türkiye. In: Chaimowitz G, Mamak M, Moulden H, Kingston D, eds. Global perspectives in forensic psychiatry: International approaches to practice, policies, and the law. London: Routledge; 2026:244–268. doi:10.4324/9781003376248-25.

Brief Interventions In Alcohol And Substance Use Disorders

Ebru Aldemir
İzmir Tınaztepe University, Department of Psychiatry

Brief interventions are structured and time-limited clinical approaches aimed at reducing risky alcohol and substance use, as well as the medical, psychiatric, and social problems that may arise from such use. These interventions include screening, assessment, providing feedback, offering recommendations for change, and follow-up. They have a wide range of applications, from primary healthcare settings to emergency departments and psychiatric clinics. Their applicability by healthcare professionals from various disciplines and their cost-effectiveness make brief interventions an important public health tool.

The fact that alcohol and substance use disorders follow a course similar to chronic diseases such as diabetes and hypertension suggests that effective outcomes can be achieved with less intensive interventions when cases are identified early. In this context, brief interventions offer an effective preventive approach, especially for individuals with risky use who have not yet reached the level of dependence.

The theoretical foundation of brief interventions is based on the Stages of Change Model defined by Prochaska and DiClemente. According to this model, individuals go through stages of precontemplation, contemplation, preparation, action, maintenance, and relapse in the process of behavioral change. Planning the intervention in accordance with the individual's current stage of change helps reduce resistance, increase motivation, and enhance engagement in treatment.

The main goal of brief interventions is to reduce the risk of harm associated with substance use. Complete abstinence is not necessarily the ultimate goal for every individual; reducing use, limiting risky behaviors, or referring to treatment are also clinically meaningful goals. In this process, the FRAMES model and motivational interviewing techniques are frequently used, and individualized feedback is provided based on risk levels determined through screening tools such as AUDIT, CAGE, and DAST-10.

Within the scope of this course, the following topics will be covered: determining the level of risk in alcohol and substance use, principles of clinical use of screening tools, structuring brief interventions in line with the Stages of Change Model, core components of motivational interviewing techniques, goals of brief interventions in risky use versus dependence-level use, and basic approaches to planning the follow-up process.

References

1. Aldemir E. Alkol ve Madde Kullanım Bozukluğunda Kısa Müdahale. In: Evren C (ed). Alkol ve Madde Kullanım Bozuklukları Temel Kitabı. Turkish Psychiatric Association Publications. Istanbul: Bayt Publishing Services; 2019.
2. Barry KL. Brief Interventions and Brief Therapies for Substance Abuse. Treatment Improvement Protocol (TIP) Series 34. SAMHSA; 1999.
3. National Institute on Alcohol Abuse and Alcoholism (NIAAA). Helping Patients Who Drink Too Much: A Clinician's Guide. NIH Publication No: 07–3769; 2007.

Ethics Committees

Ayşe Kurtoğlu
Department of Medical History and Ethics, Ankara University Faculty of Medicine, Ankara, Türkiye

Research ethics committees are institutional bodies that identify, discuss, and advise on the ethical issues arising from research and professional practice. Their primary duty is to protect the rights, safety, and well-being of participants, while balancing scientific progress with individual rights and sustaining public trust in science. Their necessity is as historical as it is theoretical: abuses such as the Nazi experiments, the Tuskegee syphilis study, and Willowbrook made prospective, independent review indispensable.

In Türkiye, ethics review began in 1993 and has evolved through successive regulations to the current Regulation on Clinical Trials of Medicinal Products for Human Use (Beşeri Tıbbi Ürünlerin Klinik Araştırmaları Hakkında Yönetmelik, 2023). Several committee types now coexist. Clinical trials ethics committees evaluate interventional research on medicinal products, including bioavailability and bioequivalence studies. Non-interventional research ethics committees review surveys, interviews, retrospective archive studies, and observational work—the bulk of psychiatric research—where no new intervention is introduced. Hospital and clinical ethics committees provide advisory, non-binding guidance on dilemmas in care, while animal experiment ethics committees assess studies involving animals under the 3R principle. Committees are independent and multidisciplinary and include a lawyer and a lay member; a member with a conflict of interest may not participate in discussion or voting.

A submission progresses through defined stages: protocol preparation, assembly of the application file, a preliminary check, rapporteur assessment, the committee meeting, and notification of the decision. The dossier is extensive—the protocol, informed-consent and, where relevant, child-assent forms, participant insurance, budget, data storage, anonymisation and destruction plans, conflict-of-interest declarations, and institutional permissions. A decision may be approval, approval after revision, lack of jurisdiction, rejection, or suspension of an ongoing study.

These procedures are underpinned by the requirements that make research ethical, as set out by Emanuel and colleagues: social or scientific value, scientific validity, fair participant selection, a favourable risk–benefit ratio, independent review, informed consent, and respect for enrolled participants, together with attention to what happens after a study ends. Ethics-committee review is the mechanism that puts these requirements into practice.

Two practical points deserve emphasis. Approval must be obtained before any contact with participants or any data collection—retrospective and pilot studies included—and any

subsequent change to an approved protocol requires a further application before it is implemented. Understood this way, ethics-committee approval is not a bureaucratic formality but the start of an ethically sustained research process. The ability to prepare and appraise an application is a core competence for every clinician who conducts or supervises research, particularly in psychiatry.

References

1. Beşeri Tıbbi Ürünlerin Klinik Araştırmaları Hakkında Yönetmelik (2023) T.C. Resmî Gazete, 27 Mayıs 2023, Sayı: 32203.
2. Emanuel EJ, Wendler D, Grady C (2000) What makes clinical research ethical? JAMA 283:2701-2711.
3. World Medical Association (2025) World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Participants. JAMA 333:71-74.

Research Ethics

Abdullah Yıldız
Department of Medical History and Ethics, Ankara University Faculty of Medicine, Ankara, Türkiye

Research ethics is often reduced to publication ethics and academic promotion, yet its central concern is the integrity of the research process itself and the duty to protect those who take part in it. History makes this concrete. In the Tuskegee syphilis study (1932-1972), the United States Public Health Service observed hundreds of poor Black men without treating them, even after penicillin became standard therapy in 1947, so that the untreated course of the disease could be documented. Their poverty and racial subordination were constitutive of the design, not incidental to it. Its exposure in 1972 reshaped the regulation of human research and produced the Belmont Report (1979). Psychiatry carries its own contested legacy in washout and symptom-provocation designs, where withdrawing or challenging treatment has been associated with relapse, rehospitalisation, and suicide.

Contemporary research ethics rests on the four-principles framework of Beauchamp and Childress (respect for autonomy, non-maleficence, beneficence, and justice), together with derived rules such as privacy and confidentiality. They do not decide cases on their own, but they structure the weighing of competing interests and sustain public trust in science.

Psychiatric research poses distinctive challenges. Because psychiatric disorders can affect decision-making capacity, patients may be vulnerable intrinsically, through cognitive impairment, mood or psychotic symptoms, and fluctuating capacity, and extrinsically, through stigma, coercion, or socioeconomic disadvantage. A diagnosis alone, however, does not equate to incapacity. Capacity should be assessed across understanding, appreciation, reasoning, and the ability to express a choice, using a sliding-scale threshold that rises with the stakes of the decision.

Crucially, protection must not become exclusion. The 2024 revision of the Declaration of Helsinki calls for under-represented groups to be given appropriate opportunity to participate: the harms of exclusion, entrenched inequities and a thinner evidence base, must be weighed against the harms of taking part. When clinicians study their own patients, the therapeutic and research relationships overlap, generating therapeutic misconception, power imbalances, and conflicts of interest. Safeguards include separating the two roles, delegating consent to an independent person, and reaffirming that withdrawal will not affect care. Valid consent accordingly requires adequate information, capacity, and voluntariness free from coercion or undue influence.

Scientific conduct spans a spectrum: misconduct (fabrication, falsification, plagiarism) at one pole, responsible conduct at the other, and questionable research practices such as selective reporting, p-hacking, and gift or ghost authorship in between. Legitimate authorship requires all four criteria of the International Committee of Medical Journal Editors. Honest error and good-faith disagreement are not misconduct.

Research ethics is therefore a core competence not only for researchers but for every clinician who refers patients to studies and safeguards both participants and the credibility of medicine.

References

1. Beauchamp TL, Childress JF (2019) Principles of Biomedical Ethics, 8th ed. New York, Oxford University Press.
2. World Medical Association (2025) World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Participants. JAMA 333:71-74.
3. International Committee of Medical Journal Editors (2024) Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals. www.icmje.org (Accessed 15 April 2026).

The Primary Challenge in ADHD Is Attention

Denizhan Değirmenci

Introduction: The traditional understanding of ADHD has long been addressed within a framework focused on "behavioral inhibition and self-regulation," largely due to the influence of Russell Barkley. However, modern systems neuroscience data reveal that the self-regulation deficits observed in the clinical picture actually develop secondary to errors in attentional regulation and arousal within neural networks. The primary thesis defended in this presentation is that ADHD is not merely a matter of focusing skills, but rather a dysfunction in the key systems underlying all executive functions.

Neurocognitive Hierarchy and Network Dynamics: To understand the pathophysiology of ADHD, it is mandatory to examine the interactions between the brain's large-scale networks. The "Triple Network Model," defined by Vinod Menon (2011), has proven that the primary defect in ADHD is a "switching" error within the Salience Network. In this model, the attentional networks (SN) that encode the significance of a stimulus fail to suppress internal noise (DMN) and activate the task-oriented network (CEN). Consequently, it is biologically impossible to achieve "self-regulation" over data that has not been processed or prioritized at the network level.

Default Mode Interference: Performance fluctuation, the most characteristic feature of ADHD phenomenology, is explained by the "Default Mode Interference" hypothesis introduced to the literature by Sonuga-Barke and Castellanos (2007). This hypothesis posits that the internal network (DMN), which cannot be suppressed during an external task, periodically "invades" the attentional networks. This network interference causes the individual to make errors not because they "cannot stop," but because they have lost the flexibility of inter-network switching (attentional lapse).

Conclusion: When epidemiological data and treatment responses are examined, it is observed that self-regulation problems such as hyperactivity and impulsivity go into remission with age, while attentional deficits remain as the "trait" core of the disorder. The fundamental problem in ADHD is not a broken brake mechanism, but the driver's (attentional system) inability to regulate the signals that illuminate the road.

Current Pharmacological Treatment Approaches in Obsessive–Compulsive Disorder

İbrahim Gündoğmuş
Department of Psychiatry, Ankara Etlik City Hospital, Ankara, Türkiye

Obsessive–Compulsive Disorder (OCD) is a chronic psychiatric disorder characterized by recurrent obsessions and compulsions, leading to substantial impairment in psychosocial functioning and quality of life. Although Cognitive Behavioral Therapy, particularly Exposure and Response Prevention, remains the cornerstone of treatment, pharmacotherapy continues to play an indispensable role, especially in patients with moderate-to-severe symptoms or when access to psychotherapy is limited. Advances in the understanding of the neurobiology of OCD have contributed to the refinement of current treatment strategies and the development of novel pharmacological interventions.

This presentation will provide a concise overview of the current evidence and international guideline recommendations regarding the pharmacological management of OCD. First-line treatment with Selective Serotonin Reuptake Inhibitors (SSRIs) will be discussed, emphasizing the need for higher therapeutic doses and longer treatment durations compared with other psychiatric disorders. Particular attention will be given to the importance of maintaining an adequate therapeutic trial for 8–12 weeks before evaluating treatment response, thereby avoiding premature changes in pharmacotherapy. Evidence supporting switching between SSRIs and the role of clomipramine in patients with an inadequate response to initial treatment will also be reviewed.

The second part of the presentation will focus on evidence-based augmentation strategies for treatment-resistant OCD. The efficacy, appropriate patient selection, dosing considerations, and safety profiles of second-generation antipsychotics, particularly risperidone and aripiprazole, will be summarized based on current clinical evidence. In addition, emerging pharmacological approaches targeting the glutamatergic system, including memantine, N-acetylcysteine, lamotrigine, and topiramate, will be discussed in light of recent clinical studies. International clinical practice guidelines will be reviewed to highlight the importance of a structured, stepwise, and individualized treatment algorithm in routine clinical practice.

In conclusion, the pharmacological management of OCD extends beyond the selection of appropriate medications and requires optimization of treatment dose and duration, implementation of evidence-based augmentation strategies, and individualized treatment planning. Integrating current scientific evidence into clinical decision-making is expected to improve long-term outcomes and provide more effective and personalized management for patients with treatment-resistant OCD.

References

1. Roh D, Jang KW, Kim CH. Clinical advances in treatment strategies for obsessive-compulsive disorder in adults. Clin Psychopharmacol Neurosci. 2023;21:676–685.
2. Gautam M. Clinical recommendations for augmentation agents in obsessive-compulsive disorder partially responsive to serotonin reuptake inhibitors. J Clin Psychopharmacol. 2023;43:369–377.

Content, Mechanisms Of Action, And Medical Indications Of Medical Cannabis

Elif Ateş Budak
Dicle University, Faculty of Medicine, Department of Psychiatry

Medical cannabis or medical marijuana includes cannabis products derived from the Cannabis sativa plant or synthetic cannabinoids which are prescribed by clinicians for medical reasons. Cannabis sativa contains more than 500 bioactive compounds and has been used for medicinal purposes for thousands of years. However, there are two most well-known and studied components: tetrahydrocannabinol (THC) and cannabidiol (CBD). THC has psychoactive effects while CBD is non-psychoactive and utilised for various therapeutic purposes. Along with these, minor cannabinoids such as cannabigerol (CBG) and flavonoids have gained attention recently for their potential effects on health.

The main mechanism of action of these compounds is via interaction with endocannabinoid system (ECS) which is a network regulating physiological homeostasis. ECS includes (cannabinoid receptor type 1) CB1 and (cannabinoid receptor type 2) CB2 receptors. CB1 receptors are mainly located in the central nervous system and are associated with analgesia, appetite, memory, while CB2 receptors are in immune cells and are responsible for anti-inflammatory and immune modulation effects. THC acts as a partial agonist at CB receptors while CBD has low affinity for these receptors and acts through alternative pathways including serotonin receptors. The psychoactive feature of cannabis is mainly due to THC's effects on CB1 receptors which lead to euphoria and altered sense of time with acute use. However, high doses can trigger anxiety, and paranoia. Additionally, chronic use has been shown to be related with cognitive impairment, memory problems, even gait problems and it can increase risk of psychosis. Interestingly, CBD has neuroprotective and anti-inflammatory effects; it is not intoxicating and it can help with adverse effects of THC such as anxiety.

There is growing evidence supporting the medical use of cannabis in recent years. Substantial evidence suggests efficacy in management of chronic and neuropathic pain, and in multiple sclerosis related spasticity. Purified CBD has been approved for treatment resistant seizures in Dravet syndrome and Lennox–Gastaut syndrome. Additionally, synthetic cannabinoids are used for chemotherapy induced nausea and appetite stimulation. There is also emerging research for its use in neurodegenerative diseases because of its neuroprotective potential. Evidence for psychiatric conditions has revealed heterogeneous results.

Medical cannabis treatments are generally well tolerated. However, they can lead to adverse effects such as dizziness and significant psychiatric symptoms and can worsen existing psychiatric illnesses. Moreover, variations in product standards pose a challenge for dosing.

Therefore, medical supervision should be carried carefully for side effects, each patient should be evaluated individually, and dosing should be gradual.

Overall, medical cannabis appears as a promising therapeutic option for certain conditions, however further large-scale randomized controlled trials are still needed to understand its efficacy, to standardize dosing and to ensure long-term safety.

References

1. Hoch E, Hall W, Friemel C ve ark. (2025) Cannabis, cannabinoids and health: A review of evidence on risks and medical benefits. Eur Arch Psychiatry Clin Neurosci 275:281-292.
2. Stella N (2023) THC and CBD: Similarities and differences between siblings. Neuron 111(3):302-327.
3. Zhai X, Sarkar PR, Hill KP (2025) Therapeutic use of cannabis and cannabinoids: benefits and risks. Pol Arch Intern Med 135(11):17117.

Boundary Violations and Non-Scientific Practices: New Methods of an Old Enemy

Emre Mutlu
Hacettepe University Faculty of Medicine, Department of Psychiatry

Non-scientific practices (NSP) are as ancient as the history of medicine itself. These practices typically involve claims that are inconsistent with current medical knowledge, often proving useless or even harmful to the public. While the core nature of medical quackery remains unchanged, practitioners have adopted modern methods to propagate misinformation. These individuals often exploit their academic "doctor" titles and professional backgrounds to gain credibility while simultaneously attacking modern medical science.

A significant challenge in psychiatry is the gap between the need for treatment and actual service utilization. For instance, while the 12-month prevalence of Major Depressive Disorder (MDD) is approximately 4.6%, only 16.5% of those affected receive minimally adequate treatment. This treatment gap is exacerbated by barriers such as stigma, lack of accurate information, and socio-economic disparities. Consequently, patients often turn to alternative information sources. Research indicates that while only 12.0% of individuals prioritize health professionals as their primary source of information, 44.4% rely on social media and 40.6% on social circles. This digital environment allows for the rapid spread of misinformation, such as false claims that antidepressants alter DNA, cause cancer, or lead to permanent personality changes.

The digitalization of health services, including telepsychiatry, presents both opportunities and new ethical challenges. While telepsychiatry is recognized as a valid component of health services when following ethical and privacy standards, the field is currently facing "education inflation". The proliferation of short-term, non-scientific certification programs and unregulated online therapy platforms creates significant boundary violations. Many of these platforms prioritize commercial gain over clinical evidence, often using marketing tactics like "discounted sessions" to attract vulnerable populations.

In conclusion, combating misinformation and non-scientific practices in their new forms requires a collective and multi-stakeholder approach. It is essential for psychiatrists, psychologists, pharmacists, and media professionals to collaborate on projects that ensure public access to evidence-based information. Only through such solidarity can a visible and lasting impact be made on public health and the prevention of boundary violations in mental health services.

References

1. Erdoğan N (2020). Şarlatanlık ve Tıp. İstanbul, İstanbul Tabip Odası Yayınları.
2. Thornicroft G, Chatterji S, Evans-Lacko S.ve ark. (2017) Undertreatment of people with major depressive disorder in 21 countries. Br J Psychiatry 210(2), 119–124.

Comparative Critical Evaluation of the Findings and Discussion of the Adult Mental Health Profile 1 (1998) and 2 (2023) Studies

Ali Gökhan Eşim
Alsancak Nevvar Salih İşgören State Hospital, Psychiatry Department

Ece Durmuşoğlu
Manisa Mental Health and Diseases Hospital, Psychiatry Department

Hatice Öztürk
Adana City Training and Research Hospital, Psychiatry Department

The Türkiye Mental Health Profile studies, conducted in 1998 and 2023, aim to establish a national database; however, they necessitate a rigorous critical evaluation regarding their methodological choices and political positioning . This analysis seeks to discuss both studies not merely through the data obtained, but through the structural limitations and biases inherent in their production processes.

A primary focus of concern is the failure in sampling and field accessibility. In the 1998 study, only 86.4% of the targeted households were reached. The inability to meet targets in metropolitan areas and regions with security concerns (e.g., rural Diyarbakır) raises significant questions about data representativeness. Furthermore, the reliance on outdated frameworks like Household Identification Forms and electricity registry lists risks excluding unregistered populations and marginalized groups. The inclusion and exclusion criteria further compromise the results. By excluding non-Turkish speakers, individuals with severe physical illnesses, or those with intellectual disabilities, the research risks rendering specific ethnic or disadvantaged groups invisible. Given Turkey's cultural and demographic diversity, such exclusions lead to inherently biased outcomes.

Epidemiological data is not just a biological indicator; it reflects the social and political atmosphere. However, these Profile studies have failed to holistically address the impact of major stressors such as mass traumas, economic crises, and social conflicts. Crucially, as these studies are conducted under the Ministry of Health, the interpretation of data often avoids critical engagement with state health policies. The "service planning" goal mentioned in the 1998 report remained a pragmatic data collection effort for maintaining the status quo rather than questioning structural issues.In conclusion, this working group aims to open a debate on what these studies "conceal" rather than what they "reveal," ranging from sampling biases to

the neglect of political determinants. The objective is to establish a new ground for consensus that offers a methodological, political, and ethical perspective for future research.

References

1. Erol N, Kilic C, Ulusoy M, Kececi M, Simsek Z. Mental Health Profile of Turkey: Prevalence of Mental Health and Mental Disorders in the Adult Population. Ankara, Republic of Türkiye Ministry of Health Publications, 1998.
2. Republic of Türkiye Ministry of Health. Turkey Mental Health Profile 2023 Results Report. Ankara, Ministry of Health Publications, 2024.

Managing Pharmacotherapy in Adult ADHD: What Should We Know and How Should We Put It into Practice?

Ali Kandeğer
Department of Psychiatry, Faculty of Medicine, Selçuk University

Attention-deficit/hyperactivity disorder (ADHD) is a neurodevelopmental disorder that is not limited to childhood and may continue to cause significant symptoms and functional impairment in adulthood. The treatment of ADHD in adults frequently involves pharmacological intervention, which is generally regarded as a first-line approach to symptom management. However, treatment is more effective when planned within an individualised and comprehensive framework.

Pharmacological treatment options can broadly be divided into stimulant and non-stimulant medications. Stimulants, particularly methylphenidate and amphetamine derivatives, increase dopamine and noradrenaline availability and produce significant improvements in the core symptoms of ADHD. They are the most commonly preferred and generally the most effective agents for the treatment of ADHD in adults. Nevertheless, it should be recognised that stimulants may be associated with tolerability problems, adverse effects, or a risk of misuse in some individuals.

Non-stimulant medications may be preferred when these risks need to be minimised or when an adequate response to stimulants cannot be achieved. Atomoxetine, a selective noradrenaline reuptake inhibitor, was the first non-stimulant medication approved for the treatment of ADHD. In addition, alpha-2 adrenergic agonists such as guanfacine and clonidine may be beneficial, particularly in the presence of comorbid anxiety, sleep disturbances, or tic disorders.

This presentation will provide an overview of the mechanisms of action, dosing strategies, adverse-effect profiles, and monitoring recommendations for medications used in the treatment of ADHD in adults. It will also address psychiatric comorbidities, individual factors that influence medication selection, and clinical approaches aimed at improving treatment adherence.

Although pharmacological treatment is a key tool for improving functioning in adults with ADHD, the best outcomes are achieved when it is combined with psychoeducation, psychosocial support, and psychotherapy when indicated.

References

1. Semerci B, Aksoy UM. *Dikkat Eksikliği Hiperaktivite Bozukluğu (DEHB) Erişkin Tanı ve Tedavi Rehberi*. TPD Publications; 2022.
2. Cortese S, Bellgrove MA, Brikell I, et al. Attention-deficit/hyperactivity disorder in adults: Evidence base, uncertainties and controversies. *World Psychiatry*. 2025;24(3):347–371. doi:10.1002/wps.21374.
3. Faraone SV, Bellgrove MA, Brikell I, et al. Attention-deficit/hyperactivity disorder. *Nat Rev Dis Primers*. 2024;10:11. doi:10.1038/s41572-024-00495-0.

Barriers to Social Functioning: Empathy, Autistic Traits, and Social Anxiety

Ali Kandeğer
Department of Psychiatry, Faculty of Medicine, Selçuk University

Attention-deficit/hyperactivity disorder (ADHD) can have a substantial impact not only on academic and occupational functioning but also on interpersonal relationships and social life. Difficulties such as interrupting others, appearing not to listen, struggling to maintain the flow of a conversation, arriving late for appointments, and failing to adequately monitor social feedback may lead to recurrent misunderstandings and social withdrawal in adults with ADHD. Social functioning difficulties in ADHD cannot be explained solely by symptoms of inattention, hyperactivity, and impulsivity. Social cognition is a multidimensional construct encompassing theory of mind, defined as the ability to understand the thoughts and intentions of others; cognitive empathy, referring to the ability to understand another person's perspective; and emotional empathy, referring to the capacity to respond emotionally to the feelings of others. Furthermore, because of the neurodevelopmental overlap between ADHD and autism, autistic traits involving social communication, cognitive flexibility, and reciprocity may contribute to social difficulties in adults with ADHD even in the absence of a clinical diagnosis of autism.
In our recent study, 142 adults with ADHD and 104 healthy controls were compared in terms of social cognition and social functioning. Adults with ADHD exhibited higher levels of autistic traits, social anxiety, and avoidance, together with lower levels of cognitive and emotional empathy. In contrast, performance on a theory-of-mind task assessing the ability to infer mental states from the eyes did not differ between the groups. Social skills and communication difficulties, difficulty switching attention, lower cognitive empathy, and higher emotional empathy were associated with social anxiety and avoidance independently of ADHD, depressive, and general anxiety symptoms.
These findings indicate that social barriers in ADHD cannot be explained simply by a "lack of empathy" or by a generalised theory-of-mind deficit. Some adults may be strongly affected by the emotions of others while simultaneously having difficulty interpreting their thoughts and intentions. Although they may perform adequately on structured tests, they may need to expend considerable mental effort to apply these abilities in the rapid and ambiguous social situations encountered in everyday life. Recurrent misunderstandings and negative social experiences may, over time, reinforce social anxiety, avoidance, and isolation.
This presentation will explore, through clinical examples, the relationships among empathy profiles, autistic traits, theory of mind, attentional flexibility, and social anxiety in adults with

ADHD. The importance of understanding social difficulties not as an individual deficit alone, but within the context of reciprocal mismatches between the individual and the social environment, will be discussed. Potential targets for social skills training, executive-function support, and interventions addressing social anxiety will also be considered.

References

1. Kandeğer A, Allison C, Çelik ME, et al. Examining social barriers in adults with ADHD: The role of autistic traits, empathy, theory of mind in social anxiety and avoidance. *Acta Psychiatr Scand*. 2026;153:279–289. doi:10.1111/acps.70067.
2. Bora E, Pantelis C. Meta-analysis of social cognition in attention-deficit/hyperactivity disorder: Comparison with healthy controls and autistic spectrum disorder. *Psychol Med*. 2016;46(4):699–716. doi:10.1017/S0033291715002573.
3. Cortese S, Bellgrove MA, Brikell I, et al. Attention-deficit/hyperactivity disorder in adults: Evidence base, uncertainties and controversies. *World Psychiatry*. 2025;24(3):347–371. doi:10.1002/wps.21374.

Approaching the Angry Patient Through Schema Therapy: A Case Formulation

Zehra Naz Mehter Çoğan
Samsun City Hospital, Department of Psychiatry, Samsun, Türkiye

Anger is one of the most common presenting complaints in psychiatric practice; however, it frequently represents a secondary emotional response rather than the primary clinical problem. Understanding the underlying psychological mechanisms is essential for accurate case conceptualization and effective intervention. This presentation aims to demonstrate how Schema Therapy can be used to formulate anger through an illustrative clinical case.

The patient was a 32-year-old married woman working in an administrative position who sought psychiatric help because of recurrent anger outbursts, particularly within close relationships. She reported intense emotional reactions when she perceived criticism, failure, or unfair treatment. During these situations, she exhibited shouting, blaming others, and interpersonal withdrawal, followed by feelings of guilt, worthlessness, and fear of losing important relationships. She also described prominent physiological arousal preceding anger, including palpitations, muscle tension, facial flushing, and an increasing sense of internal pressure.

Clinical assessment included the Hamilton Depression Rating Scale, the Young Schema Questionnaire, and the Schema Mode Inventory. Results suggested moderate depressive symptoms together with elevated scores in the Defectiveness/Shame, Failure, and Unrelenting Standards schemas. Prominent schema modes included the Vulnerable Child, Angry Child, and Punitive Parent modes. Developmental history revealed a highly critical family environment in which academic success was strongly emphasized, mistakes were poorly tolerated, and the patient frequently experienced feelings of inadequacy.

The proposed schema formulation suggests that perceived criticism initially activates the Vulnerable Child mode through Defectiveness or Failure schemas. Subsequently, the patient attempts to cope by overcompensating, leading to Angry Child activation and externalized anger toward others. Following the anger episode, the Punitive Parent mode becomes dominant, resulting in self-criticism, guilt, and reactivation of maladaptive schemas. This repetitive cycle contributes to persistent interpersonal difficulties and emotional distress.

Therapeutic interventions focus on increasing awareness of schema modes, identifying maladaptive coping responses, weakening the Punitive Parent mode through limited reparenting and experiential techniques, restructuring dysfunctional beliefs, improving emotion regulation skills, and strengthening the Healthy Adult mode. Viewing anger as the behavioral expression of unmet emotional needs rather than an isolated symptom may facilitate individualized treatment planning and improve long-term therapeutic outcomes. Furthermore, this formulation highlights the clinical value of addressing underlying schemas instead of focusing solely on anger control, providing a comprehensive framework for long-term recovery and relapse prevention.

References

1. Young JE, Klosko JS, Weishaar ME. Schema Therapy: A Practitioner's Guide. New York: Guilford Press; 2003.
2. Arntz A, Jacob G. Schema Therapy in Practice: An Introductory Guide to the Schema Mode Approach. Oxford: Wiley-Blackwell; 2013.
3. Rafaeli E, Bernstein DP, Young JE. Schema Therapy: Distinctive Features. London: Routledge; 2011.

Cognitive Behavioral Therapy for Gambling Disorder: From Assessment to Relapse Prevention Workshop Abstract

Fatıma Mükerrem Güven

Gambling Disorder is a behavioral addiction associated with significant psychological, social, and financial consequences. Cognitive Behavioral Therapy (CBT) is recognized as the first-line psychological treatment, with strong evidence supporting its efficacy. This interactive workshop provides clinicians with practical, evidence-based CBT strategies for the assessment and treatment of Gambling Disorder. Participants will learn how to identify cognitive distortions, conduct functional analyses, develop individualized case formulations, implement cognitive restructuring and behavioral interventions, manage cravings, and strengthen relapse prevention skills. Clinical case examples, experiential exercises, and practical tools will facilitate the translation of research findings into everyday clinical practice. Current evidence from randomized controlled trials and meta-analyses will be integrated throughout the workshop to support evidence-informed decision-making.

Learning Objectives

At the end of this workshop, participants will be able to:

- Describe the cognitive-behavioral model of Gambling Disorder.
- Identify cognitive distortions and behavioral maintaining factors associated with gambling.
- Apply evidence-based CBT techniques, including cognitive restructuring, behavioral interventions, and craving management.
- Develop individualized CBT case formulations and relapse prevention plans.
- Integrate current research findings into clinical practice for the treatment of Gambling Disorder.

Recent Regulatory Updates in Military Psychiatric Evaluation

Aslıhan Bilge Bektaş
Department of Psychiatry, University of Health Sciences Türkiye, Izmir Faculty of Medicine, Izmir City Hospital, İzmir, Türkiye

Recent amendments to the Turkish Armed Forces, Gendarmerie General Command and Coast Guard Command Health Capability Regulation have introduced substantial changes in the psychiatric evaluation of military applicants and active personnel. Rather than modifying diagnostic criteria, these revisions primarily redefine how psychiatrists interpret psychiatric history, remission, functional recovery and future risk during fitness-for-duty assessments. The present presentation reviews the major psychiatric components of the updated regulation and discusses their implications for contemporary clinical practice.

One of the most important changes is the transition from declaration-based assessment to documentation-based evaluation. Psychiatric fitness decisions increasingly rely on longitudinal electronic medical records, documented treatment history and objective clinical evidence. Previous psychiatric diagnoses are no longer considered absolute contraindications; instead, clinicians are expected to evaluate illness trajectory, recurrence, treatment duration, current mental status and prognostic indicators before determining fitness.

The updated regulation also introduces clearer remission criteria for several psychiatric disorders. For individuals with previous adjustment disorders, anxiety disorders and attention-deficit/hyperactivity disorder (ADHD), eligibility decisions now require documented periods without psychiatric diagnosis, pharmacological treatment or clinically significant symptoms. These revisions shift the emphasis from lifetime psychiatric history to sustained functional recovery and documented clinical stability.

Another notable development is the increased incorporation of behavioural risk indicators into psychiatric evaluations. Information obtained from forensic records, documented behavioural problems and previous disciplinary issues may contribute to the assessment of long-term occupational suitability in selected personnel groups. In parallel, newly defined operational roles, including unmanned aerial vehicle (UAV) operators, require psychiatric assessments that place greater emphasis on sustained attention, cognitive performance and psychological reliability.

Collectively, these revisions reflect a broader conceptual shift in military psychiatry. The psychiatrist's responsibility extends beyond diagnosing mental disorders to evaluating documented recovery, functional capacity and operational risk within a standardized legal

framework. Accordingly, contemporary military psychiatric evaluation has become a structured process integrating clinical assessment, longitudinal medical documentation and occupational decision-making.

These regulatory updates are expected to improve standardization, reduce variability in clinical decision-making and strengthen the transparency of psychiatric fitness evaluations. Understanding these changes is therefore essential for psychiatrists involved in military, occupational and forensic mental health assessments.

Keywords: military psychiatry; attention-deficit/hyperactivity disorder; remission; occupational psychiatry

References

1. Türkiye Cumhuriyeti Millî Savunma Bakanlığı (2025) **Türk Silahlı Kuvvetleri, Jandarma Genel Komutanlığı ve Sahil Güvenlik Komutanlığı Sağlık Yeteneği Yönetmeliği.** Ankara, Millî Savunma Bakanlığı.
2. American Psychiatric Association (2022) *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition, Text Revision (DSM-5-TR). Washington DC, American Psychiatric Association.

Patient Selection and Expectation Management in Non-Pharmacological Treatment of Sexual Dysfunctions

Aslıhan Bilge Bektaş
Department of Psychiatry, University of Health Sciences Türkiye, Izmir Faculty of Medicine, Izmir City Hospital, İzmir, Türkiye

Sexual dysfunctions cannot be adequately understood through physiological mechanisms alone. Sexual response is shaped by the interaction of biological capacity, emotional experience, learned beliefs, interpersonal patterns, cultural expectations, and the meaning attributed to sexuality. For this reason, non-pharmacological interventions are particularly relevant when the presenting complaint is maintained by performance anxiety, avoidance, maladaptive sexual beliefs, impaired communication, or relational distress.

Patient selection is a central component of treatment planning. Individuals with vaginismus, dyspareunia, psychogenic erectile dysfunction, performance-related sexual difficulties, or persistent symptoms despite medical treatment may benefit from psychotherapeutic and behavioural interventions. These approaches are also valuable when pharmacotherapy is contraindicated, poorly tolerated, or insufficient to address the psychological and relational dimensions of the problem. Before treatment, however, acute psychosis, untreated severe depression, interpersonal violence, severe relationship instability, and psychiatric conditions that may interfere with therapeutic participation should be assessed carefully.

Readiness for active participation is more informative than symptom severity alone. Non-pharmacological treatment requires the individual, and when appropriate the partner, to engage in psychoeducation, behavioural exercises, observation of automatic thoughts, and gradual changes in established interaction patterns. Expectations of rapid or externally delivered recovery may reduce adherence. By contrast, the capacity to view treatment as a learning process facilitates behavioural change and supports the development of sexual self-efficacy.

Expectation management is therefore not an additional element of treatment but one of its principal therapeutic mechanisms. Beliefs such as the necessity of uninterrupted arousal, constant readiness, simultaneous orgasm, or a fixed duration of intercourse may transform ordinary fluctuations in sexual response into evidence of failure. These assumptions increase self-monitoring and performance anxiety, disrupt attention to erotic stimuli, and reinforce avoidance. Cognitive and behavioural interventions aim to replace performance-oriented

standards with a broader understanding of pleasure, intimacy, responsiveness, and mutual communication.

Relational assessment is equally important because sexual symptoms frequently emerge within reciprocal patterns of withdrawal, pressure, resentment, or misinterpretation. Partner participation may help reduce blame, improve communication, and create a safer context for gradual behavioural tasks. In women presenting with low desire, explaining responsive desire within Basson's circular model may also reduce self-stigmatization by demonstrating that desire may emerge after emotional or physical engagement rather than preceding it.

Non-pharmacological treatment is most likely to succeed when the intervention matches the individual's clinical presentation, motivation, relational context, and capacity for sustained participation. The therapeutic goal is not merely the removal of a symptom, but the reconstruction of a more flexible, secure, and satisfying sexual experience.

Keywords: sexual dysfunctions; non-pharmacological treatment; patient selection; expectation management; sexual therapy

References

1. Basson R (2000) The female sexual response: A different model. J Sex Marital Ther 26: 51-65.
2. Brotto LA, Atallah S, Carvalho J ve ark. (2025) Psychological and interpersonal dimensions of sexual function and dysfunction: Recommendations from the Fifth International Consultation on Sexual Medicine (ICSM 2024). Sex Med Rev 13: 118-43.
3. Frühauf S, Gerger H, Schmidt HM ve ark. (2013) Efficacy of psychological interventions for sexual dysfunction: A systematic review and meta-analysis. Arch Sex Behav 42: 915-33.

Approaches Beyond Pharmacotherapy in Treatment-Resistant Depression

Aslıhan Bilge Bektaş
Department of Psychiatry, University of Health Sciences Türkiye, Izmir Faculty of Medicine, Izmir City Hospital, İzmir, Türkiye

Treatment-resistant depression (TRD) is commonly defined as the absence of a satisfactory clinical response despite at least two antidepressant trials administered at adequate doses and for sufficient durations. However, before concluding that depression is genuinely resistant, diagnostic accuracy, treatment adherence, adequacy of previous interventions, psychiatric and medical comorbidities, substance use, and possible bipolarity should be reconsidered. Distinguishing true resistance from pseudo-resistance is essential because it determines both the treatment pathway and the expected outcome.

The clinical complexity of TRD cannot be explained solely by monoaminergic dysfunction. Glutamatergic abnormalities, impaired neuroplasticity, altered brain-derived neurotrophic factor signalling, inflammatory processes, hypothalamic-pituitary-adrenal axis dysregulation, and disrupted functional connectivity have all been implicated in resistant depressive states. In particular, persistent rumination and impaired cognitive control have been associated with abnormalities in large-scale neural networks, including the default mode network. These findings provide a biological rationale for interventions that modify cortical excitability and neural connectivity more directly than conventional antidepressants.

Electroconvulsive therapy (ECT) remains the most effective somatic treatment for severe TRD, particularly when rapid improvement is required because of marked functional deterioration, psychotic symptoms, catatonia, or high suicide risk. Its clinical value must nevertheless be considered alongside the need for anaesthesia and the possibility of cognitive adverse effects. Repetitive transcranial magnetic stimulation (rTMS) offers a non-invasive alternative, usually targeting the dorsolateral prefrontal cortex, with a favourable cognitive and systemic adverse-effect profile. Evidence suggesting superiority of rTMS augmentation over switching antidepressants supports its consideration at an earlier stage of treatment algorithms. Transcranial direct current stimulation (tDCS) is less established than ECT or rTMS but remains clinically relevant because of its portability, relatively low cost, and ease of administration. Vagus nerve stimulation (VNS) may provide gradually emerging and sustained benefits in chronic, highly resistant cases, whereas deep brain stimulation (DBS) continues to be investigated for individuals with profound and persistent treatment resistance. Neuroplasticity-

based cognitive rehabilitation and digitally delivered cognitive interventions may also be useful when executive dysfunction and impaired cognitive control contribute to ongoing disability. Management of TRD should therefore not be reduced to repeated medication changes. Treatment selection should reflect the severity and chronicity of depression, urgency of clinical need, previous treatment history, cognitive status, physical health, patient preference, and accessibility of specialised interventions. The central aim is not only symptomatic improvement, but also restoration of functioning and prevention of relapse through an individualized, multimodal treatment plan.

Keywords: treatment-resistant depression; neuromodulation; electroconvulsive therapy; repetitive transcranial magnetic stimulation; neuroplasticity

References

1. McIntyre RS, Alsuwaidan M, Baune BT ve ark. (2023) Treatment-resistant depression: Definition, prevalence, detection, management, and investigational interventions. World Psychiatry 22: 394-412.
2. Mutz J, Vipulananthan V, Carter B ve ark. (2019) Comparative efficacy and acceptability of non-surgical brain stimulation for the acute treatment of major depressive episodes in adults: Systematic review and network meta-analysis. BMJ 364: l1079.
3. Reddy S, Kabotyanski KE, Hirani S ve ark. (2024) Efficacy of deep brain stimulation for treatment-resistant depression: Systematic review and meta-analysis. Biol Psychiatry Cogn Neurosci Neuroimaging 9: 1239-48.

Differential Diagnosis in Obsessive-Compulsive Disorder and Related Disorders

Aslıhan Bilge Bektaş
Department of Psychiatry, University of Health Sciences Türkiye, Izmir Faculty of Medicine, Izmir City Hospital, İzmir, Türkiye

Obsessive-compulsive disorder (OCD) is frequently recognized through intrusive thoughts and repetitive behaviours; however, neither feature is specific to the disorder. Appearance-related preoccupations, stereotyped routines, motor repetitions, fixed beliefs, rumination and impulsive acts may resemble obsessions or compulsions despite arising from different psychopathological processes. Differential diagnosis therefore requires attention not only to what an individual thinks or does, but also to how the experience is formed, what function it serves and how it is related to the sense of self.

The contemporary obsessive-compulsive spectrum challenges a simple opposition between compulsivity and impulsivity. Although compulsions are commonly performed to reduce distress or neutralize a perceived threat, some repetitive behaviours are driven by sensory discomfort, reward seeking, incompleteness or poorly articulated internal urges. Impulsivity and compulsivity may coexist, and their overlap can be clinically relevant to illness severity, comorbidity and treatment response.

Body dysmorphic disorder (BDD) and OCD both involve persistent preoccupations and repetitive acts. In BDD, however, beliefs and behaviours are organized around perceived defects in appearance, and conviction may approach delusional intensity. The degree of insight and the specific object of concern are therefore more informative than the repetitive quality of the behaviour itself. In autism spectrum disorder (ASD), repetitive behaviours may regulate sensory overload, preserve predictability or support emotional organization. Unlike typical compulsions, they are not necessarily preceded by intrusive threat-based thoughts and
may be experienced as congruent with the individual's needs. Developmental history, sensory phenomena and the response to interruption are central to this distinction.

The boundary between obsession and delusion is particularly difficult when insight is limited. Obsessions are usually experienced as intrusive and resisted, even when their plausibility is overestimated. Delusions are more fully integrated into the individual's interpretation of reality and are less available to critical reconsideration. Assessment should therefore include conviction, resistance, ownership of thought, reality testing and the wider organization of the belief system. Obsessive-compulsive symptoms may also occur during the prodromal or

established phases of schizophrenia-spectrum disorders and can be associated with greater symptom burden and poorer functioning.

A reliable differential diagnosis cannot be based on symptom content alone. The clinical task is to identify the phenomenological structure of the experience: its relationship to the self, its emotional and behavioural function, the level of insight and its place within the person's developmental and longitudinal course. This formulation is essential because superficially similar behaviours may require substantially different therapeutic approaches.

References

1. Bilge Bektaş A (2026) Obsesif kompulsif bozukluk ve ilişkili bozukluklarda ayırıcı tanı. Psikiyatride Güncel 16: 153-70

Foster Care, Citizenship, Employment, Driver Licensing, and Psychotechnical Evaluations in Psychiatry:
Assessment Principles and Clinical Practice

Ali Gökhan EŞİM,
Alsancak Nevvar Salih İşgören State Hospital, Department of Psychiatry, İZMİR

Foster Care Evaluations

Individuals applying to become foster parents are required to submit medical reports certifying that they do not have any physical or mental health conditions that could adversely affect a child's care or psychosocial development. These reports are prepared by psychiatrists, who assess the applicant's capacity to undertake the parental role. However, the absence of clearly defined legal criteria specifying which psychiatric conditions constitute contraindications to foster parenting presents significant challenges in clinical practice. Discussion of the practical difficulties encountered by psychiatrists, together with illustrative case examples, is essential for promoting greater objectivity, consistency, and transparency in the assessment process.

Citizenship Evaluations

Mental health evaluations requested as part of the citizenship application process represent a common component of psychiatric practice. However, the lack of standardized guidelines or reporting frameworks for psychiatric assessment in this context complicates clinical decision-making. Furthermore, issues such as anti-immigrant prejudice, stigma, and discrimination frequently arise during these evaluations, underscoring the psychiatrist's ethical responsibility to ensure that assessments remain objective, unbiased, and free from discriminatory attitudes. This presentation will discuss practical approaches to citizenship evaluations through representative clinical cases while emphasizing principles of equity and non-discrimination.

Pre-employment Psychiatric Evaluations

Pre-employment psychiatric assessments aim to objectively evaluate the impact of an individual's mental health status on occupational functioning and fitness for work. Appropriate vocational placement of individuals with psychiatric disorders is essential for both workplace safety and employee well-being. During these evaluations, psychiatrists must consider not only the applicant's functional capacity but also potential risks to coworkers and the work environment, while simultaneously avoiding unnecessary exclusion and reducing stigma associated with mental illness. Common clinical challenges and illustrative case examples will be presented to facilitate evidence-informed and ethically sound decision-making in occupational psychiatric evaluations.

Driver Licensing and Psychotechnical Evaluations

The mental health status of drivers is of critical importance for both individual and public safety. Consequently, psychiatric evaluations conducted for driver licensing should carefully assess the effects of current psychiatric disorders and psychotropic treatments on driving performance and safety. In addition to determining driving fitness, psychiatrists should provide recommendations regarding the need for periodic reassessment and the appropriate intervals for follow-up examinations when clinically indicated. Major challenges encountered in driver fitness and psychotechnical evaluations will be discussed using examples drawn from routine clinical practice.

References

1. https://www.mevzuat.gov.tr/mevzuat?MevzuatNo=18615&MevzuatTur=7&MevzuatTertip=5 -İşyeri Hekimi Ve Diğer Sağlık Personelinin Görev, Yetki, Sorumluluk Ve Eğitimleri Hakkında Yönetmelik
2. Psikiyatride Rapor Düzenleme Kılavuzu 2. Baskı, TPD Yayınları https://www.mevzuat.gov.tr/File/GeneratePdf?mevzuatNo=10664&mevzuatTur=KurumVeKurulusYonetmeligi&mevzuatTertip=5- Sürücü Adayları Ve Sürücülerde
3. Aranacak Sağlık Şartları İle Muayenelerine Dair Yönetmelik

Cancer and Sexuality

Ali Gökhan EŞİM,
Alsancak Nevvar Salih İşgören State Hospital, Department of Psychiatry, İZMİR

Cancer is not merely a cellular pathology but a profound existential crisis that disrupts an individual's bodily integrity, sexual identity, and sense of self. Although the pathological process originates at the cellular level, the course of diagnosis and treatment extends far beyond the physical boundaries of the body, fundamentally altering the individual's relationship with both the self and the surrounding world. Within this context, sexuality transcends its biological function and emerges as a core dimension of identity, self-esteem, intimacy, and interpersonal connectedness. Cancer treatments—including surgery, chemotherapy, and radiotherapy—induce permanent anatomical, hormonal, neurological, and vascular alterations that directly impair sexual functioning. Despite the high prevalence of treatment-related sexual dysfunction, sexual health remains substantially underrecognized and undertreated in routine oncology practice. This presentation aims to comprehensively examine the pathophysiological mechanisms, psychiatric implications, and clinical management of sexual dysfunction associated with cancer and its treatment.

The effects of cancer therapies—including surgery, chemotherapy, and radiotherapy—on sexual functioning are complex and multifactorial. At the pathophysiological level, pelvic surgeries may result in erectile dysfunction, vaginal dryness, and impaired sexual arousal through autonomic nerve injury, hormonal disturbances, and anatomical alterations. Chemotherapy contributes to gonadal damage, endocrine dysfunction, and premature menopause, whereas radiotherapy induces tissue fibrosis, vaginal stenosis, and vascular injury. However, cancer-related sexual dysfunction extends well beyond biological mechanisms. Disturbances in body image resulting from mastectomy, stoma formation, alopecia, and treatment-related weight changes frequently lead to diminished sexual self-confidence, body alienation, grief reactions, depression, and anxiety. These psychosocial consequences often constitute some of the most significant determinants of impaired sexual health, exceeding the impact of biological injury alone.

The restoration of sexual health following cancer requires a multidisciplinary, holistic, and individualized approach involving oncologists, psychiatrists, psychologists, sexual health specialists, nurses, physiotherapists, and social workers. Evidence-based clinical management includes psychosexual counseling based on the PLISSIT model, nurse-led sexual rehabilitation programs, pharmacological interventions—including local estrogen therapy, vaginal lubricants, and phosphodiesterase type 5 (PDE5) inhibitors—and physical rehabilitation strategies such as

pelvic floor muscle training and vaginal dilator therapy. Within this multidisciplinary framework, psychiatrists play a central role in the assessment and treatment of psychiatric comorbidities, the management of body image disturbances, interventions targeting sexual identity and sexual self-esteem, and couples therapy, while also serving as key coordinators of integrated care. Sexual health should not be regarded as an unavoidable cost of cancer survivorship but rather recognized as a fundamental component of quality of life and an indispensable element of comprehensive oncological care.

References

1. Chow, K. M., Chan, C. W. H., Choi, K. C., Siu, K. Y., Wong, C. L., Cheng, K. K. F., & Ip, W. Y. (2024). Multicentre randomized controlled trial of a nurse-led sexual rehabilitation intervention to rebuild sexuality and intimacy after treatment for gynecological cancer. *Psycho-Oncology*, *33*(1), e70004. https://doi.org/10.1002/pon.70004
2. Frey, A. U., Sønksen, J., & Fode, M. (2014). Neglected side effects after radical prostatectomy: A systematic review. *The Journal of Sexual Medicine*, *11*(2), 374-385. https://doi.org/10.1111/JSM.12403
3. Kerie, S., Menberu, M., & Niguse, W. (2021). Erectile dysfunction among testicular cancer survivors: A systematic review and meta-analysis. *Heliyon*, *7*(7), e07479. https://doi.org/10.1016/J.HELIYON.2021.E07479

Two Sides of the Coin in Pharmacological Treatment: Current Evidence and Clinical Limitations

Ali Gökhan EŞİM,
Alsancak Nevvar Salih İşgören State Hospital, Department of Psychiatry, İZMİR

Sexual dysfunctions are clinically significant conditions that adversely affect quality of life, intimate relationships, and psychological well-being. According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR), these disorders include male hypoactive sexual desire disorder, erectile disorder, premature (early) ejaculation, female sexual interest/arousal disorder (FSIAD), genito-pelvic pain/penetration disorder (GPPPD), and female orgasmic disorder. Pharmacological treatment has become an integral component of managing these conditions. However, an important therapeutic paradox exists: selective serotonin reuptake inhibitors (SSRIs), which are widely prescribed for psychiatric disorders, frequently impair sexual functioning and may themselves cause DSM-5-TR-defined substance/medication-induced sexual dysfunction, raising important ethical concerns regarding iatrogenic harm.

Pharmacological interventions differ according to the specific type of sexual dysfunction. In genito-pelvic pain/penetration disorder, botulinum toxin injections have been investigated to reduce pelvic floor muscle hypertonicity through inhibition of acetylcholine release at the neuromuscular junction, while topical lidocaine and benzodiazepines may alleviate pain and anxiety. Nevertheless, evidence supporting the routine use of botulinum toxin remains limited, and psychosexual therapies continue to represent the standard of care. For female sexual interest/arousal disorder, FDA-approved treatments include daily oral flibanserin, which enhances dopaminergic and noradrenergic neurotransmission, and on-demand subcutaneous bremelanotide administered before anticipated sexual activity. In addition, low-dose systemic testosterone has demonstrated efficacy in selected postmenopausal women. In premature ejaculation, dapoxetine, administered 1–3 hours before intercourse, transiently inhibits serotonin reuptake, thereby increasing ejaculatory latency. Because dizziness and syncope may occur, patients should be advised to take the initial dose while seated. Daily off-label pharmacotherapy with paroxetine, clomipramine, or sertraline may also be considered, preferably in combination with behavioral interventions such as the stop-start technique. Conversely, antidepressant-induced sexual dysfunction occurs in approximately 30–70% of patients receiving SSRIs and may affect every phase of the sexual response cycle. Paroxetine and fluvoxamine are associated with the highest risk, whereas sertraline and fluoxetine demonstrate intermediate risk. Neurobiologically, enhanced serotonergic activity suppresses

mesocorticolimbic dopamine transmission via 5-HT2A receptor activation, reducing sexual desire and motivation. Simultaneously, 5-HT2C receptor activation inhibits erection and ejaculation, while reduced nitric oxide synthase activity compromises genital blood flow and vaginal lubrication. Hyperprolactinemia may further impair libido by suppressing gonadotropin-releasing hormone secretion and gonadal steroid production. Management strategies include watchful waiting, dose reduction, or brief drug holidays for short-acting agents, although the strongest evidence supports switching to antidepressants with lower rates of sexual adverse effects, such as bupropion, mirtazapine, or agomelatine, or augmenting treatment with phosphodiesterase type 5 inhibitors, buspirone, or bupropion.

Ultimately, pharmacotherapy for sexual dysfunction represents a double-edged sword, offering substantial therapeutic benefit while also carrying the potential for treatment-induced sexual adverse effects. Consistent with the ethical principle of *primum non nocere* ("first, do no harm"), clinicians should routinely assess sexual functioning before and during treatment, counsel patients regarding potential adverse effects, and incorporate shared decision-making into clinical practice. A patient-centered and multidisciplinary approach to sexual health remains essential for optimizing treatment adherence, preserving quality of life, and improving overall therapeutic outcomes.

References

1. American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., Text Revision; DSM-5-TR). American Psychiatric Publishing.
2. Serretti, A., & Chiesa, A. (2009). Treatment-emergent sexual dysfunction related to antidepressants: a meta-analysis. *Journal of Clinical Psychopharmacology*, 29(3), 259–266.
3. Clayton, A. H., & Alkis, A. R. (2016). Hypoactive Sexual Desire Disorder: A Review of Epidemiology, Biopsychology, Diagnosis, and Treatment. *Sexual Medicine Reviews*, 4(2), 103–120.

ICOM ZEVENT
Intelligent Alliance

Maslak Mah. Büyükdere Cad. U.S.O. Center No:245
Kat.15 34453 Sarıyer-İstanbul/Türkiye

+90 212 323 5100 +90 212 323 5100 info@zevent.com.tr

Address: Z Event Congress Services Kft., 1032 Budapest, Föld utca
53. pinceszint 1. Ajtó, Hungary

www.zevent.com.tr