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Review Article

A Gloomy Guy

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Abstract

The cell constitutes the fundamental structural and functional unit of all tissues and organs in multicellular organisms. As a self-regulating biological system, it integrates a vast array of specific, metabolic, energetic, protective, and informational functions.

Cellular pathology, characterized by structural and functional disturbances, represents the foundational pathological process underlying human disease [1]. This article provides a comprehensive overview of the core principles of cell damage, detailing the principal mechanisms of injury, including energy metabolism disruption, membrane and enzyme system damage, ion imbalance, genetic program dysregulation, and signaling pathway failures [15]. The molecular pathways and morphological features of the main types of cell death—necrosis, apoptosis, autophagy, and senescence—are examined [10, 13]. Furthermore, the review explores the critical role of mitochondrial and lysosomal pathology [7, 20], outlines fundamental cellular adaptation mechanisms [2, 19], and discusses specific disease entities arising from organelle dysfunction, such as lysosomal storage disorders. Understanding these processes is essential for deciphering the pathogenesis of a wide spectrum of conditions, from ischemic injury and neurodegenerative diseases to cancer and inherited metabolic disorders [4].

Keywords: psychiatric disorders; suicide; suicide attempt; first admission; recurrent admission; schizophrenia; bipolar disorder; depression; substance abuse disorder

Introduction

A young man, in a traditional community, and in his third decade of life, had been referred by a primary care physician to a consultant psychiatrist for a psychological probe or, if necessary, treatment. His major motive for referral, as well, was the patient's lengthy feelings of downheartedness, recurrent nags, and non-adherence to prescribed medications, evaluations, or therapeutic advice. In his initial psychiatric interview, which, unsurprisingly, was not pleasant to him, the establishment of a therapeutic alliance did not seem to be an easy task, and the risk of noncompliance, negative transference, and countertransference, too, was not moderate. Accordingly, insight-oriented interviews or psychotherapy could not be among prime diagnostic or therapeutic alternatives, respectively. In addition to diabetes type II and gastritis in his medical history, which were followed by the said internist, his past psychiatric history revealed some unsatisfying treatments with tricyclic antidepressants (imipramine and amitriptyline) and selective serotonin reuptake inhibitors (fluoxetine). As said by him, all prior treatments, though not completely ineffective,

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future mating. His wishes or ambitions, which could not be formulated as well. Since he was reluctant to speak about his kinfolks, nothing important regarding family history could be discovered. Similarly, while nihilistic ideas or negativistic thought were evident in his attitude, there was not any substantial account of suicidal ideation or attempts. In the mental status examination (MSE), no remarkable impairment, except for a sad mood, was detectable. Though intellectualization and rationalization were among his obvious cognitive mechanisms for explanation of events, available data regarding his object relations, loss, or internal conflicts were, in general, poor. In his personal history, no important social or occupational problem was evident. Likewise, since, except for the patient, no other reliable resource for gathering data career as a clerk in one of the public agencies, though okay, could not satisfy his was available, proper judgment regarding his personality development, familial relationship, social habits, and criminal history was not feasible, though as stated by him, no important piece of information that could change the direction of the ongoing evaluation had been purposefully omitted by him. Anyhow, based on the existing findings, he was diagnosed as a case of mild to moderate major depressive disorder, which could have been superimposed on a current dysthymia as well, and by considering his drug history, in addition to his medical history, he was prescribed sertraline, 50 milligrams per day, and was referred to an experienced counselor for further inquiry. In the following meeting, he said that he did not meet the counselor, but the said medication was okay, and, on the word of him, his temper was much better than before, though it was not enough. Therefore, the sertraline was increased to 100 milligrams per day, which, as stated by him, improved his mood meaningfully, and he sensed that it was enough for him, an achievement that was apparently unchanging for a while. After a few months, in spite of promising follow-up visits and acceptable mental status checkups, he suddenly attempted suicide by drug overdose, according to personnel of the department of emergency, which was naturalized partially because he left there hurriedly. After questioning by his psychiatrist, he explained, elusively, that incident as an inadvertent event and emphasized that it was not due to worsening of temper or suicidal ideas. The said psychiatrist, as well, assumed that instance was a possible case of 'paradoxical suicide' and asked for more frequent visits or contacts, though he felt a bit responsible or regretful for the too rapid increase in dosage of sertraline. Over again, for around a few weeks, the whole thing, ostensibly, seemed to be good. But, after some time, more or less, the same event happened once more, with similar incredible explanations. After release from the hospital, he disappeared for a while, and while he missed the next few visits, he did not respond to the doctor's office follow-up phone calls. Nonetheless, eventually, after another month, he visited his psychiatrist again, and while his MSE, disposition, and attitude were amazingly favorable, and there was no problem regarding his therapeutic compliance, he stated an alternative elucidation with respect to the aforesaid suicidal attempts. As said by him, every suicidal attempt was immediately after an incident of sodomy with a same-sex partner, and they were not the only ones. He had such incidents previously as well, though he obliterated them consciously during opening interviews. He had started such odd relationships a few years ago, when he was an adolescent, escorted by indecisiveness, embarrassment, and frequent cover-ups. He was finding his partners online, via social media, momentarily and unthinkingly, and without any idea for a long-term relationship. He could not explain clearly whether such an attempt was due to a lack of heterosexual objects, owing to a core sensual desire, or whether it was just gratification of a pubescent inquiry. According to him, his attempted suicides, as well, were almost impetuous and upon an increasing sense of self-disgust and could be accounted as some kind of inexorable reprimands for a sin that should never happen. Neither of his relatives, friends, or colleagues was aware of that, and he was trying persistently to keep it secret for prevention of possible harm to his social or occupational situation. As a result, he and his random sexual partners were, by and large, anonymous to each other. Moreover, while he could not explain why he was behaving so ambivalently, he could not guarantee that he might not do it again, in spite of its potential risks. According to him, the said cycle was the main reason for his erratic bitterness, and without that, everything could be okay. When he was asked why at this time he was confessing to an event that he had concealed during the last years, he replied that maybe it was because he was going to relocate soon, and he may never meet his counselor again to say that his suicidal attempt was not 'paradoxical,' which he had heard accidentally from personnel, but it was justified, according to his verdict. Anyhow, this indicated to the therapist that, while the insight-oriented interview or approach was not pleasing to him, the ensued rapport was a bit operative and might show that the patient's insight was, metaphorically, more towards a true emotional insight than a merely intellectual one; that is to say, he was demanding, ambivalently, assistance. Besides, it might have originated from a general instinctual pressure in a wrongdoer to take responsibility for his wrongdoing, for undoing the sense of guilt in a person devoid of super-ego lacuna. On the other hand, such confession could have originated from a conscious or subconscious signaling or appraisal, which may ultimately appear in all similar situations. Every sinner, in addition to pleading for exoneration, consciously may demand generalization of sin, unconsciously, as an indirect gizmo for finding an accomplice and rationalizing sin. At any rate, a homosexual relationship in a traditional community, especially when it is not against the will, may create a never-ending social stigma, which may not be handled definitively, rightfully, or therapeutically. Furthermore, in keeping with some studies, verbal hostility from healthcare providers toward homosexual individuals and internalized homophobia (IH), which is defined as the inward direction of societal homophobic behaviors at the individual level and refers to the subjective psychological effect of these negative outlooks, are meaningfully associated with a high prevalence of internalizing mental conditions such as anxiety, depression, or stress/trauma-related disorders among these minority groups [1-3]. In this regard, homophobia is defined as a range of feelings, behaviors, and negative attitudes towards sexual variations and persons recognized or supposed as homosexual. The origin of the term denotes a combined term stemming from the words 'homosexuality' and 'phobia,' which is a Greek term meaning 'dread' or 'fear' or 'aversion.' Homophobia relies on cultural, political, and religious beliefs and standards. Similarly, negative attitudes towards homosexuality are motivated by the concept of heteronormativity (a principle according to which heterosexuality is the standard for legitimating social and sexual relationships, whereas homosexuality may be appreciated as an abnormal variant) [4, 5]. Likewise, internalized homophobia (IH) may be demarcated as the inward direction of societal homophobic attitudes at the individual level. It is a psychological concept including the internalization of negative outlooks conflicting with the self-regard and leading to identification with the heterosexual beliefs, or a self-denigration. This course may cause distress with one's own sexual orientation, which may be grasped as ego-dystonic: personal cravings and temptations are understood as at odds with the personal self-image and may cause extreme tension, repression, clinical depression, and a greater risk of suicide [6]. Accordingly, while, globally, suicide is the fourth leading cause of death amongst young people, amongst this young population, lesbian, gay, bisexual, and trans young people have higher rates of suicidal thoughts and attempts than their heterosexual peers [7, 8]. On the other hand, while terminological or taxonomical modifications, whether caringly or cautiously, may not obscure the strangeness of a phenomenon behind the status quo, it may decline disciples' confidence seriously, and turn sympathy into antipathy. Anyhow, after a few exchanges of ideas and recommendations, he promised to continue his medications under the supervision of a psychiatrist in his new region and, if necessary or obtainable, to resort to counseling meetings for finding an apt solving strategy before further impulsive acts. As could be expected, after leaving the clinic, he never returned back [9-13].

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