Psychology Research and Behavior Management

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LETTER

Suicidality and Its Association with Stigma in Clinically Stable Patients with Schizophrenia in Rural China [Letter]

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Dear editor

I recently read with keen interest the article by Wang et al that investigates the relationship between suicidality and stigma among clinically stable patients living with schizophrenia in China's rural Anhui Province.[1] Given that suicide is a leading cause of death among individuals with schizophrenia, elucidating associated risk factors represents a crucial area for research.[2] Whilst I commend the authors for their contributions on this important subject, I believe there are some aspects of the study that warrant further reflection. As a final year medical student with a background in medical anthropology, I aim to provide some pertinent insights and recommendations in this letter.

My initial concern revolves around the consistent use of the term "commit suicide" throughout the paper.[1] Considering the focus of the study, the role of language in either perpetuating or alleviating stigma cannot be overstated. Given the historical and present-day criminalisation of suicide in different parts of the world, the word "commit" inadvertently insinuates undertones of misconduct.[3] I believe that it is vital for medical professionals to be acutely aware of their language choices. Opting for terms that are less stigmatising holds the potential to transform perceptions, making a world of difference.[3] I would thus propose replacing "committed suicide" with a more neutral phrase such as "died by suicide".

Secondly, the authors' decision to use the Social Impact Scale (SIS) to assess stigma among Chinese patients diagnosed with schizophrenia merits discussion.[1] Psychometric tools such as the SIS, originally developed in English, may not resonate universally across varied cultural landscapes.[4] Whilst high Cronbach's alpha values suggest internal consistency,[1] this does not necessarily ensure the suitability of the SIS in diverse settings. Creating tools that are culturally appropriate and tailored to address specific manifestations of stigma are crucial for designing effective interventions.[4] Accordingly, I advocate for a robust validation of the SIS within this specific demographic to further substantiate the study's findings.

Furthermore, the standards employed in the study to determine clinically stable patients are debatable, describing this as less than a 50% change in psychiatric medication over the past three months.[1] Considering the authors' own observation that individuals in rural areas face limited access to medical resources,[1] I urge a re-evaluation of these criteria. This is because a lack of regular medical check-ups can lead to misleading indications regarding a patient's clinical stability.

Lastly, the authors highlighted that patients displaying negative schizophrenia symptoms sometimes offer self-assessments that do not mirror the actual situation.[1] I would argue that this potential discrepancy is not limited to patients with negative symptoms alone. Given the neurocognitive deficits often associated with positive symptoms of schizophrenia,[2] these individuals can struggle to accurately gauge their cognitive and functional capacities.[5] To mitigate inconsistencies in self-assessments across a patient cohort exhibiting both positive and negative symptoms, incorporating feedback from collateral informants could enhance confidence in the results.

Received: 25 September 2023
Accepted: 30 September 2023
Published: 3 October 2023

In conclusion, I sincerely appreciate the authors' contributions to this journal and trust that my comments will be taken in the constructive spirit in which they are offered.

Disclosure

The author reports no conflicts of interest in this communication.

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https://doi.org/10.2147/PRBM.S441937