

Psychiatry and Addiction Medicine in Russia: Spots of Bother

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Abstract

Selected aspects of Russian psychiatry and addiction medicine are delineated in this review. Some cited literature is not new as ethical issues are less openly discussed nowadays. Certain human factors have remained unchanged since the Soviet time, so that persistence or relapse of abusive practices is not excluded. Two case reports are presented, illustrating, how the diagnosis may depend on the patient's social status. Vague diagnostic criteria of sluggish schizophrenia affected many people, having nothing to do with politics or dissent. Personality disorders, neuroses and transient derangements in adolescence have been diagnosed and treated as schizophrenia. Along with the extended diagnostic criteria of the disease, a broader concept of social dangerousness has been applied, facilitating hospitalization. Antipsychotics have been recommended for all varieties of schizophrenia. Furthermore, the use of neuroleptics for treating alcoholism and other addictions in Russia extends beyond internationally accepted indications. Overtreatment of patients diagnosed with alcohol use disorder, discussed in preceding papers, is briefly summarized here. Conditions in psychiatric hospitals, where patients stay for long time, are briefly tackled. Some institutions are investing in major repairs of buildings but overcrowding persists both in wards and in restrooms. In conclusion, temporary practice of Russian doctors abroad and of authorized foreign advisors in Russia is recommended.

Introduction

The abuse of psychiatry in the former Soviet Union (SU) was often discussed during the second half of the 20th century. In the 21st century, the interest to this topic has decreased, which does not mean that the problem has remained in the past. In addition to political pressures, the causes of abuse can include low standards of training and practice, insufficient procedural quality assurance [1], limited access to foreign professional literature and poorly implemented legislation because professionals have not been trained to use the new laws, or lacking motivation to use them [2]. Some human and political factors have remained unchanged since the Soviet times, so that persistence or relapse of suboptimal practices seems to be probable.

Case reports

Case 1

A rather typical case illustrating overdiagnosis of schizophrenia in the former SU has been reported [3]. A 16-year-old schoolboy (hereinafter patient) with mild communication abnormalities was brought to the psychiatrist by his mother. Later, the patient admitted that the real goal was exemption from military service (conscription). The author observed him for many years and did not notice any mental abnormalities, apart from alcohol dependence that developed



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later on. Aside from shyness during adolescence, the only notable complaint was the statement that his “nerves were like ropes”. This was interpreted as cenesthopathy, and sluggish schizophrenia was diagnosed. The concept of cenesthopathy was coined to describe unusual bodily sensations without objective findings; it is no longer in the mainstream of contemporary psychiatry [4,5]. However, Russian literature has many publications on cenesthopathy that culminated in the singling out of cenesthopathic [6-8] or “negative- cenesthopathic” form of schizophrenia [9]. Besides, cenesthopathy has been posited as a symptom of hypochondriacal and sluggish schizophrenia. It is known that some forms of adolescent turmoil may lead clinicians to diagnose a serious condition, to be confronted one day with a recovered patient; although severe disorders in adolescence usually do not disappear completely [10].

The patient spent a month in a psychiatric hospital for examination and was diagnosed with sluggish schizophrenia. Prescriptions included a phenothiazine drug and trihexyphenidyl (known as Cyclodol in Russia). There was no proper control of the drug intake. The patient brought Cyclodol tablets to school and offered to others with the comment that it was a narcotic drug. Curious teenagers took it during lessons, which remained unnoticed by teachers. One boy suffered intoxication with a delirium-like condition after an intake of trihexyphenidyl together with alcohol. The patient was registered with the psycho-neurological dispensary, exempted from conscription, denied a driver's license and directed to a specialized educational institution, where he acquired the profession of floriculturist. After that he worked in city parks. Later on, following advice of his friends and some medics, the patient switched to car repair work, completed an evening technical education, got married, and reduced his alcohol consumption. The patient suffered from stigma all his life: registration at the psycho-neurological dispensary was known by surrounding people, which impaired his relationships and employment possibilities. Apparently, this contributed to the alcohol abuse.

Case 2

A student was expelled for poor academic performance from a university in one of the Soviet republics and conscripted to the army. During the first month of his service, the patient encountered conflicts and appealed to relatives to help him be recognized unfit for military service. His father was a military functionary, later retired as colonel. Within a month the patient was dismissed from the army and registered with the psycho-neurological dispensary with a diagnosis of “psychasthenia”. No antipsychotics were prescribed to him. Later on, the patient migrated to Moscow, got rid of the registration with the dispensary and obtained a driver’s license.

The Cases 1 and 2 describe malingering or aggravation in order to avoid military service. More details about malingering of mental disorders are in the preceding article [11]. The patient with a low social status (Case 1) was diagnosed with schizophrenia, remained registered with the psycho-neurological dispensary and stigmatized lifelong. The individual with connections to the military establishment (Case 2) was diagnosed with psychasthenia and got rid of the registration after a few years. On the contrary to Case 1, no antipsychotics were prescribed to him; the patient was permitted to obtain a driver’s license. Psychasthenia has been vaguely delineated in the Russian literature; described symptoms partly overlapped with those of sluggish schizophrenia [12,13]. The latter diagnosis entailed more stigma, exclusion from many forms of skilled and professional work, having also other social consequences. As shown by Cases 1 and 2, the use of diagnostic entities sometimes depended on the social status. Some relatives of higher officers and functionaries evaded conscription under various pretexts.

Psychiatry: selected aspects

The concept of schizophrenia has been broader in the former SU than in other countries [14-16]. Overextended diagnostic criteria of sluggish schizophrenia affected many people, having nothing to do with politics or dissent [17]. Personality disorders, neuroses and transient derangements in adolescence have been misdiagnosed and treated as schizophrenia. It can be illustrated by the following citations (from Russian): “A part of the patients with sluggish schizophrenia, after a juvenile crisis, achieved a complete social and professional adaptation, continued education and got married” [18] or “A majority of patients with juvenile sluggish schizophrenia become compensated” [19]. The high percentage of favorable outcomes [20] is an indirect evidence of false-positivity. Schizophrenia was considered a lifelong process [21,22]. Accordingly, patients remain registered with psycho-neurological dispensaries lifelong, which contributes to stigma for them and their families.

The procedure of cancellation of registration with the dispensary has been rare and usually unsuccessful [14]. Especially in totalitarian societies, it is unlikely that socially unprotected patients would initiate legal remedies [23]. The registration can contribute to unemployment

because some employers ask for a certificate from a psycho-neurological dispensary. Access to foreign professional literature has been limited [24], while in Russian textbooks, differential diagnosis between personality disorders, neuroses and schizophrenia has been explained vaguely, leaving space for individual judgment. For example, in the well-known textbook [25], the differential diagnosis between sluggish schizophrenia, neuroses and personality disorders is not discussed at all, while it is only stated that many months of observation can be needed, thus justifying prolonged institutionalization. Russian psychiatrists sometimes constructed diagnoses through words, not necessarily using objective criteria, referred to as a “narrative orientation of diagnosis” [22]. The vague and subjective concept of *Praecoxgefühl* is reappearing in the current literature, being proposed as a ground for the “diagnostic hypotheses”. Lack of “transparent” contact with a patient has been posited as a criterion of the *Praecoxgefühl* [26]. Suspected schizophrenia can thus be documented if a person is not cooperative with the interrogating expert. This approach might facilitate misuse of psychiatry.

Psychopathologic phenomena typical for histrionic, dissociative, obsessive-compulsive disorders, prolonged asthenization, unusual interests, scrappy reading of professional literature and “ideas incoherent with the cultural environment” have been presented as diagnostic criteria for schizophrenia [8,27-32]. Apropos, the “scrappy reading of professional literature” [27] is necessary due to unreliability of advertizing and popular publications in medicine and other areas. The existence of latent, asymptomatic or non-manifestative forms of schizophrenia was postulated [33]. Chapters about neuroses and personality disorders have been added to recent textbooks but descriptions are rather vague [34]. Some descriptions of schizophrenia including residual conditions are compatible with the norm [27].

In some textbooks [35,36], sluggish schizophrenia has been presented as a synonym of a schizotypal personality disorder according to the International Classification of Diseases (ICD). Although the 10th Revision of ICD was accepted, the Soviet-era classification has been further in use, while ICD was criticized [37-39]. A national classification in psychopathology is discussed now as before [40]. The term sluggish schizophrenia continues to be used; it has been the most frequently diagnosed form of the disease: ~50% of all schizophrenia cases [22,35,38].

The entity was additionally expanded by “schizophrenic reactions” or “psychogenic exacerbations” of the disease that had been non-manifest prior to an environmental impact. Emphasizing of social factors (stress, deprivation) as etiological factors of schizophrenia [41] may serve as theoretical ground thereof. The term “reactive schizophrenia” has been coined [20,28]. Another contribution to the overextension of the entity was the doctrine about the “Nosos and Pathos” by the leading psychiatrist Andrei Snezhnevsky [25,42], where the manifestative disease is called Nosos

and hereditarily predisposing constitutional traits - the Pathos of schizophrenia. According to this doctrine, the Nosos can transform to the Pathos and vice versa. In this way, the disease is confounded with constitution, permitting to diagnose personality disorders and constitutional traits as schizophrenia. Snezhnevsky's works have been cited and approvingly commented until today [39].

The WHO guidelines have been used more broadly since the late 1980s [39]. Childhood autism, introduced into Russian classifications at that time but not uniformly accepted, has sometimes been classified and treated as schizophrenia [43,44]. The overlap of childhood autism with schizophrenia is discussed now as before [45-47]. Some experts should consider potential consequences of the false-positive diagnosis, exemplified by the Case 1 above.

Russian experts criticized the Western "phenomenological" approach [48]. It was claimed that the Soviet classification of mental disease is based on etiology and pathogenesis, supposed to be superior to the foreign classifications based on symptoms or syndromes [49]. Note that the etio-pathogenetic approach, in conditions of insufficient knowledge on etiology and pathogenesis and lack of diagnostic tools, contributes to overdiagnosis. "Asymptomatic" or "non-manifestative" forms of schizophrenia [33] cannot be diagnosed by a blood test like e.g. those of syphilis. In the end of his career, Snezhnevsky was disappointed by unsuccessful search for biological markers [17].

The pharmacotherapy has generally been more intense in Russia than in other countries [48]. Antipsychotic drugs have been recommended for all varieties of schizophrenia in adults and children, including the hypochondriacal and sluggish forms, suspected prodrome, as well as shizotypal disorder [9,19,20,35,50-53]. Some initially healthy or oligosymptomatic individuals were stigmatized and "driven mad" through the effects of the medication [48]. Efficiency of early treatment of mild cases was supported by anecdotal evidence [48]. The early treatment may be indeed efficient in some cases but blanket recommendations may conductive to overtreatment.

Neuroleptics have been used and recommended in such vaguely defined conditions as "psychopathological diathesis", premorbid or residual schizophrenia [32,54,55], its sluggish variety with a "simple deficit", childhood autism including Asperger's syndrome as well as neuroses and personality disorders [36,47,56]. This is partly at variance with the international literature. Tendentious citation is sometimes applied, for example, the possibility of antipsychotics use in patients with antisocial personality and borderline personality disorders was pointed out with reference to the MSD Manual [51,57]. However, the following is written in the cited source: "Typically, personality disorders are not very responsive to medications... There is no evidence that any particular treatment leads to long-term improvement [of antisocial personality disorder]... Medications are not consistently effective for core symptoms of borderline personality disorder" [57]. Side effects of antipsychotics are well known, including those contributing to the stigmatization [37].

There has been criticism of unnecessary hospitalizations (exemplified by Case 1) and lack of adequate protection of patients' rights [2,48]. Compulsory hospitalization implies compulsory treatment. The emphasis remains on medical aspects of treatment, without adequate consideration of psychosocial and occupational rehabilitation [58]. The Russian Federation had one of the highest levels of psychiatric beds per capita in Europe [59]. Admittedly, the number of psychiatric beds has decreased since the last decades [60,61].

Addiction medicine

The use of antipsychotics for treating alcoholism and other addictive disorders in Russia extends beyond the internationally accepted indications [62]. Antipsychotic drugs (phenothiazines, haloperidol and others) have been recommended and applied in adults and adolescents diagnosed with alcohol dependence in the absence of psychosis [63-67]. The above-named drugs have been administered for the treatment of withdrawal syndrome, which is generally at variance with international recommendations [68]. An inconsistent effect of atypical antipsychotics for outcomes such as craving or abstinence has been reported across studies [69]. Within the scope of antipsychotic treatment of alcohol withdrawal syndrome, haloperidol is mainly recommended for use in the intensive care unit. No other clear recommendations are available for antipsychotics use in alcohol withdrawal syndrome [70]. Clinical recommendations are avoided here.

The leading specialist for addiction medicine (called narcology in Russia) Nikolai Ivanets recommended the following doses to alleviate alcohol craving: Trifluoperazine (Stelazine) - 20-50 mg/day, Perphenazine (Etaperazine) - 10-40 mg/day, Teralen (Alimemazine) - 15-75 mg/day. Flupentixol (Fluanxol®) was recommended for the withdrawal syndrome 80-150 mg/day [71]. Quetiapine (Seroquel®) was used for the latter purpose 150-200 mg/day, which is rather high dose [72]. The alcohol craving has been interpreted as an "altered state of consciousness", as a paranoid or delusional phenomenon [73,74] within the scope of "productive psychopathology" [66]. Accordingly, the antipsychotic medication has been recommended by authoritative handbooks [65,66]. Apart from other potential side effects, the synergism between some antipsychotics and alcohol, aggravating liver injury, should be taken into account [75]. We observed a patient with ascites who continued receiving chlorpromazine. With regard to alcohol-related dementia and other dementia in alcohol consumers, it should be stressed that antipsychotics are associated with increased risks of stroke, venous thromboembolism, myocardial infarction, heart failure, fracture, pneumonia and acute kidney injury [76].

Invasive procedures performed in patients, including those diagnosed with the alcohol use disorder, has been discussed in detail previously [77]. For example, in cases with supposed comorbidity of tuberculosis and alcoholism, lung surgery was recommended earlier, after a shorter course of medical therapy. The leading thoracic

surgeon Mikhail Perelman insisted on early operations in alcoholics, and operated them also in the absence of detectable *M. tuberculosis*. The same expert noticed that alcohol-dependent patients have more frequent post-surgery complications [78]. Bronchoscopy was applied in cases with bronchitis, the latter being frequent among alcoholics in Russia due to smoking and the risk of falling asleep in a cold place. Along with other complications, vocal cord injuries were observed after repeated bronchoscopies performed in conditions of insufficient procedural quality. It was noticed that vomiting triggered by apomorphine in the framework of aversive therapy, provoked hemoptysis and pneumothorax in patients with tuberculosis [79,80]. Certain anti-tuberculosis drugs (cycloserine, rifampicin and other) exacerbated liver and neural derangements in alcoholism [79]. Nevertheless, rifampicin was officially recommended for patients with comorbidity of tuberculosis and alcohol use disorders [81]. More examples and references are in preceding publication [77].

Among others, the following treatments were applied to patients with supposed comorbidity of alcoholism, hospitalized for various reasons: prolonged intravenous infusions, sorbent hemoperfusion, endoscopic and surgical biopsies of internal organs, endoscopic cholangiopancreatography and angiography sometimes without clear indications also for research [77]. Intravenous infusions were recommended for patients with alcoholism including moderately severe withdrawal syndrome: 7-10 infusions daily, sometimes combined with intramuscular injections [63,65,80-86]. The intravenous detoxification was regarded to be "indicated to nearly all alcohol-dependent patients, especially to those with prolonged withdrawal syndrome" [80,87]. Recommendations of intravenous infusion therapy of alcohol intoxication and withdrawal syndrome with both crystalloid and colloid solutions can be found in recent instructive publications [88-90].

The recommended duration of the intravenous detoxification was 3-15 days [77,87], or even 21-30 days [80,81] according to some instructions. A more recent publication recommended 2-3 days [90]. This is generally at variance with the international practice. Alcohol and its metabolites are eliminated spontaneously while rehydration can be usually achieved per os. Long-lasting drip infusions are uncomfortable; some patients regarded them as torture. Apparently, ideation of punishment coupled with irresponsibility has played a role in some personnel. It is known that the attitude to patients supposed to have an alcohol use disorder has been less responsible with lower procedural quality assurance. Repeated infusions, endovascular and endoscopic manipulations lead to a transmission of viral hepatitis, which was known to occur rather often. This is unfavorable if combined with alcohol-related liver damage. Other invasive procedures (celiacography, endoscopic cholangiopancreatography etc.) were applied in persons diagnosed with alcohol use disorder without clear indications [84].

The ultra-rapid (one session) treatment of alcoholism, known

in the former SU as "coding", should be commented briefly. The method has been criticized for mystification, intimidation and unpleasant procedures associated with health risks. The following has been applied: spraying of the throat with ethyl chloride or infusion of 3-5 ml ethyl chloride into the pharynx with forced swallowing, pressure with therapist's thumbs on the trigeminal and occipital nerve branches, pressure on the carotid sinus areas and the patient's eyeballs, intralingual injections, forceful turning and backwards movements of the patient's head [91-94]. The latter is associated with a risk of injury for patients with vertebral abnormalities. Nevertheless, the method is in use now as before.

Discussion

The leading psychiatrist Anatoly Smulevich claimed that ~40% of patients with somatic diseases had psychiatric symptoms. The alleged prevalence of schizophrenia among patients in the general practice (4-6%) is much higher than in the population [9,48]. Considering the overdiagnosis tendency, these doubtful statements may contribute to paternalism and interfere with the principle of informed consent. Indeed, opinions and requests of patients are often disregarded. The paternalistic attitude is persisting since the Soviet time [61,68]. Under conditions of paternalism, misinformation of patients, compulsory hospitalization and treatments are deemed permissible [95].

Conditions in psychiatric hospitals, where the patients stay for a long time, have been primitive: overcrowding, no privacy, insufficient hygiene. Some institutions are investing in major repairs of buildings but overcrowding persists both in wards and in restrooms. The overcrowding of toilets is increased because patients use them for smoking. Usually there are no cubicles: lavatory pans and urinals are in the same crowded room. The problem of cigarette smoking in psychiatric hospitals has been tackled in the preceding article [96].

Furthermore, a shortage of nurses and auxiliary personnel is a problem. The auxiliary staff has been less numerous than in other countries [48]. Unprepared persons were sometimes employed without training and adequate instruction. In some cases this led to maltreatment of patients. Brutality of some personnel and inhumane treatment of patients have been pointed out [39,48]. The level of satisfaction with the quality of services in psychiatric institutions was found to be low among patients seeking treatment in private clinics [97].

Some literature cited here is not new as ethical issues are less openly discussed nowadays. Political and human factors have partly remained unchanged since the Soviet time, so that persistence or relapse of abusive practices is not excluded. In spite of a formal condemnation of the Soviet-era abuse of psychiatry, a tendency of its belittling can be noticed [38]. It was stated, for example, that conceptual differences between the Soviet and Western psychiatry have been minimal, while the abuse was caused mainly by political factors [98]. In fact, as discussed above, the Russian concept of

schizophrenia has been broader than that used in other countries. Along with the extended diagnostic criteria of the disease, a broader concept of social dangerousness has been applied [15,16]. A risk of damage to the interests of society has been presented as a criterion of social dangerousness and hence a reason for hospitalization [60,99,100]. The social dangerousness has been described as a “universal concept used to assess damage done to society” [100], which is open to political interpretations.

Conclusion

The question has been discussed why psychiatry but not physical medicine is open to abuse [98]. In fact, the physical medicine can be abused as well [101], while psychiatry is open to abuse especially in certain locations of the world, including the former SU. Not surprisingly, there is public fear of psychiatry in this country [39]. The first step away from the nuisance must include the broader use of the international literature and the exchange of experience by means of temporary practice of Russian doctors abroad and of authorized foreign advisors in Russia. More international trust and cooperation is needed.

Conflict of interest statement

The author declares no conflict of interest.

References

1. Lavretsky H (1998) The Russian concept of schizophrenia: a review of the literature. *Schizophrenia Bulletin* 24: 537-557.
2. Jenkins R, Klein J, Parker C (2005) Mental health in post-communist countries. *BMJ* 331: 173-174.
3. Jargin SV (2009) Overdiagnosis of schizophrenia: A view from Russia. *Asian J Psychiatry* 2: 119.
4. Graux J, Lemoine M, Gaillard P, Camus V (2011) Les cénesthopathies: un trouble des émotions d'arrière plan. *Regards croisés des sciences cognitives et de la phénoménologie. Encephale* 37: 361-370.
5. Simon AE, Borgwardt S, Lang, UE, Roth B (2014) Canaesthopathy in adolescence: an appraisal of diagnostic overlaps along the anxiety-hypochondriasis-psychosis spectrum. *Comprehensive Psychiatry* 55: 1122-1129.
6. Basov AM (1980) Clinical independence of cenestopathic schizophrenia. *Zh Nevropatol Psikhiatr Im S S Korsakova* 80: 586-592.
7. Jenkins G, Röhrich F (2007) From canaesthesias to canaesthopathic schizophrenia: a historical and phenomenological review. *Psychopathology* 40: 361-368.
8. Lichko AE (1992) *Tablitsy differentsirovannoy diagnostiki vyalotekushchey shizofrenii v podrostkovom i yunosheskom vozraste* (Tables of differential diagnosis of sluggish schizophrenia in adolescence and youth). *Bekhterev Psychoneurological Institute*.
9. Smulevich AB (1989) Sluggish schizophrenia in the modern classification of mental illness. *Schizophr Bull* 15: 533-539.
10. Nicholi AM Jr (1999) *The Harvard guide to psychiatry*. 3rd ed. Harvard University Press.
11. Jargin SV (2022) Malingering, sexual and reproductive coercion: Military aspects. *MedPress Case Reports and Clinical Images* 1: mpcrci-202207001.
12. Akkerman VI (1962) The Pavlovian concept of psychasthenia and schizophrenia. *Zh Nevropatol Psikhiatr Im S S Korsakova* 62: 565-572.
13. Kanareikin KF (1993) Psychasthenia - clinical variations of psychopathy. *Klinicheskaya Meditsina* 71: 3-6.
14. Birley J (2002) Political abuse of psychiatry in the Soviet Union and China: a rough guide for bystanders. *J Am Acad Psychiatry Law* 30: 145-147.
15. Bonnie RJ (2002) Political abuse of psychiatry in the Soviet Union and in China: complexities and controversies. *J Am Acad Psychiatry Law* 30: 136-144.
16. Keith SJ, Regier DA (1989) U.S. and Soviet perspectives on the diagnosis of schizophrenia and associated dangerousness. *Schizophr Bull* 15: 515-517.
17. Gindilis VM (2013) A.V. Snezhnevsky. In: Aleksandrovsky YuA. *History of Russian psychiatry in 3 volumes*. Moscow: Geotar-Media 3: 550-556.
18. Tsutsulovskaya Mla, Pekunova LG (1978) Clinical and catamnestic study of slowly progressing, juvenile schizophrenia. *Zh Nevropatol Psikhiatr Im S S Korsakova* 78: 86-94.
19. Tiganov AS, Snezhnevsky AV, Orlovskaya DD (1999) *Handbook of psychiatry*. Meditsina.
20. Kotsyubinsky AP (2015) *Autokhtonnnye nepsikhoticheskiye rasstroystva* (Autochthonous Non-Psychotic Disorders). St. Petersburg: SpetsLit.
21. Holland J, Shakhmatova-Pavlova IV (1977) Concept and classification of schizophrenia in the Soviet Union. *Schizophr Bull* 3: 277-287.
22. Reich R (2018) *State of madness: psychiatry, literature, and dissent after Stalin*. Northern Illinois University Press.
23. Franjić S (2021) Schizophrenia is a complex mental illness. *Journal of Addictive Disorders and Mental Health* 1: 1-4.
24. Murphy J, Jargin S (2017) International trends in health science librarianship part 20: Russia. *Health Info Libr J* 34: 92-94.
25. Lichko AE (1995) Schizophrenia. In: Korkina MV, Lakosina ND, Lichko A, eds. *Psychiatry*. Meditsina; 374-403.
26. Gornushenkov ID, Pluzhnikov IV (2020) Praecox-Gefühl in classical and modern researches. *Psikhiatriia* 18: 58-64.
27. Ivashinenko DM, Ilyin IV (2014) *Shizofreniya: etiopatogenez, klinika, lecheniye, reabilitatsiya* (Schizophrenia: Etiopathogenesis, Clinical Presentation, Treatment, and Rehabilitation). Tula University.
28. Il'ina NA (2006) Schizophrenic reactions: a history of the conception. *Zh Nevrol Psikhiatr Im S S Korsakova* 106: 72-89.
29. Molchanova EK (1978) Age-related dynamics of outpatient forms of schizophrenia (on the age-related dynamics of so-called latent schizophrenia in light of late catamnoses in senescence). *Zh Nevropatol Psikhiatr Im S S Korsakova* 78: 94-99.
30. Molchanova EK (1981) Clinical picture of the late stages of sluggishly-progressing schizophrenia in advanced age. *Zh Nevropatol Psikhiatr Im S S Korsakova* 81: 7715-7720.
31. Yakovlev NM, Kositskaya ZV, Karpenko MN, Slezin VB (2013) *Psikhofiziologicheskiye osobennosti shizofrenii u podrostkov* (Psychophysiological Features of Schizophrenia in Adolescents). Nestor-Istoria.
32. Kotsyubinsky AP, Sheynina NS, Chumachenko AA (2006) Psychopathological diathesis and issues of primary prevention of mental disorders. *Siberian Bulletin of Psychiatry and Addiction Psychiatry (S)*: 128-130.
33. Smulevich AB (1989) Sluggish schizophrenia in the modern classification of mental illness. *Schizophr Bull* 15: 533-539.
34. Dmitrieva TV, Krasnov VN, Neznakov NG, Semke VYa, Tiganov AS, Aleksandrovsky YuA (2009) *Psychiatry: National Manual*. Geotar-Media.
35. Korkina MV, Lakosina ND, Lichko AE, Sergeev II (2004) *Psychiatry*. Medipress-inform.
36. Zharikov NM, Tiulpin IuG (2012) *Psychiatry*. Meditsina.
37. Oslopova AA, Oslopov VN (2012) *Schizophrenia*. Kazan Medical University.

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38. Polishchuk Iul (2001) Is a clinical nosologic direction in the Russian psychiatry completely exhausted itself? Zh Nevrol Psikhiatr Im S S Korsakova 101: 69-71.
39. Aleksandrovsky YuA (2013) History of Russian psychiatry in 3 volumes. Moscow: Geotar-Media.
40. Rosman SV, Maximova NE (2026) On the issue of changing the classification of diseases in psychiatry. Psikhicheskoe Zdorovie - Mental Health 21: 65-76.
41. Khakhaleva OO, Akhmetova EA, Valinurov RG (2026) Schizophrenia: beyond the boundaries of genetic mechanisms. Psikhicheskoe Zdorovie - Mental Health 21: 31-42.
42. Snezhnevskii AV (1971) General pathology and nosology in the clinical picture of schizophrenia. Vestnik Akademii Meditsinskikh Nauk SSSR 26: 3-6.
43. Tiganov AS, Bashina VM (2005) Current approaches to understanding of autism in childhood. Zh Nevrol Psikhiatr Im S S Korsakova 105: 4-13.
44. Krasnoperova MG (2004) Clinical aspects of childhood autism with endogenous manifesting psychosis and mental retardation. Zh Nevrol Psikhiatr Im S S Korsakova 104: 5-10.
45. Makarov IV, Pashkovsky VE (2021) Detskaya shizofrenia: rukovodstvo dlya vrachev (Childhood schizophrenia: guideline for physicians). Geotar-Media.
46. Goryunov AV (2024) Controversial issues of diagnosis and theoretical concepts of schizophrenia in childhood. Zh Nevrol Psikhiatr Im S S Korsakova 124: 17-24.
47. Danilov DS, Tiulpin YuG (2010) Lechenie shizofrenii (Treatment of Schizophrenia). MIA.
48. Calloway P (1992) Soviet and Western psychiatry. A comparative study. Moor Press.
49. Zharikov NM (1999) About the handbook of psychiatry in 2 volumes, A.S. Tiganov, ed. Zh Nevropatol Psikhiatr Im S S Korsakova 100: 96-97.
50. Smulevich AB, Dubnitskaya EB, Pavlova LK (2008) Klinika, sistematika i terapiya remissii pri shizofrenii (Clinic, systematics and therapy of remissions in schizophrenia). Psikhiaatriia (2): 7-15.
51. Sivolap YP (2019) Antipsychotics: treatment of schizophrenia and other therapeutic options. Zh Nevrol Psikhiatr Im S S Korsakova 119: 74-78.
52. Bashina VM (1989) Rannaya detskaya shizofreniya. Statika i dinamika (Early childhood schizophrenia: Statics and dynamics). Moscow: Meditsina.
53. Antropov YuA (2014) Diagnosis of Mental Illnesses: Selected Lectures. Moscow: GEOTAR-Media.
54. Abramov VA, Likholetova OI, Putyatin GG (2012) Clinical analysis of the initial prodrome of schizophrenia: temporal and gender-age aspects. Zhurnal Psikhiatrii i Meditsinskoy Psikologii - Journal of Psychiatry and Medical Psychology (2): 15-29.
55. Semke AV, Rakhmazova LD, Lobacheva OA, Ivanova SA, Gutkevich EV (2006) Clinical and biological factors in the formation of adaptation in patients with schizophrenia. Siberian Bulletin of Psychiatry and Addiction Medicine 3: 17-21.
56. Bashina VM (1999) Autizm v detstve (Childhood autism). Moscow: Meditsina.
57. MSD Manual Professional Version (2019).
58. Jenkins R, McDaid D, Nikiforov A, Potasheva A, Watkins J, et al. (2010). Mental health care reforms in Europe: Rehabilitation and social inclusion of people with mental illness in Russia. Psychiatric Services 61: 222-224.
59. Jenkins R, Lancashire S, McDaid D, Samyshkin Y, Green S, Watkins J., et al. (2007) Mental health reform in the Russian Federation: an integrated approach to achieve social inclusion and recovery. Bull World Health Organ 85: 858-866.
60. Makushkina OA, Yazdovskaya AV (2022) Hospitalization in psychiatric hospitals on an involuntary basis: An analysis of its application in the Russian Federation (2011-2021). Siberian Bulletin of Psychiatry and Narcology 3: 54-62.
61. Stickley A, Koposov R, Isaksson J, Sumiyoshi T, Ponomarev OA, Ruchkin V (2026) Attitudes and ethical beliefs of Russian psychiatrists towards the use of coercive treatment practices. Int J Law Psychiatry 104: 102142.
62. Sivolap IuP (2014) Treatment of alcohol dependence: rational and arguable approaches. Zh Nevrol Psikhiatr Im S S Korsakova 114: 53-56.
63. Brazhenko NA (2005) Comorbid pathology: tuberculosis, alcohol abuse, drug addiction, hepatitis and HIV infection/AIDS. Pavlov University.
64. Lichko AE, Bitsenskii VS (1991) Podrostkovaia narkologia (Adolescent narcology). Meditsina.
65. Ivanets NN, Vinnikova MA (2011) Alcoholism. MIA. (in Russian)
66. Ivanets NN, Anokhina IP, Vinnikova MA (2016) Narcology: national manual. Geotar-Media. (in Russian)
67. Mendelevich VD, Zalmunin KY (2015) Paradoxes of evidence in Russian addiction medicine. Int J Risk Saf Med 27 Suppl 1: S102-S103.
68. Veshneva SA (2020) Medikalizatsiya v narkologii: istoriya, klinicheskiy smysl i sotsial'nyye perspektivy (Medicalization in Addiction Medicine: History, Clinical Significance, and Social Perspectives). Moscow: Ruscience.
69. Helle AC, Watts AL, Trull TJ, Sher KJ (2019) Alcohol use disorder and antisocial and borderline personality disorders. Alcohol Res 40: arcr.v40.1.05.
70. Faustmann TJ, Paschali M, Kojda G, Schilbach L, Kamp D (2025) Systematische Übersichtsarbeit Antipsychotische Behandlung des Alkoholentzugssyndroms: Fokus Delirium Tremens. Fortschr Neurol Psychiatr 93: 36-52.
71. Ivanets NN, Kinkulkina MA (2001) Treatment of alcohol dependence. Psychiatry and Psychopharmacotherapy 3: 80-83.
72. Gofman AG, Krylov EN, Varfolomeeva YuE, Kolodny VM, Sheveleva OS (2004) Comparative study of the efficacy of the new atypical antipsychotic Seroquel (quetiapine fumarate) in the treatment of patients with alcohol dependence. Narkologiya 3: 58-61.
73. Brun EA, Mikhailov MA, Avtonomov DA (2020) Izmenennyye sostoyaniya soznaniya, psihoaktivnyye veshchestva i psihoaktivnyye deistvia (Altered states of consciousness, psychoactive substances and psychoactive actions). New Terra.
74. Zobin ML (2013) Problem drinking as an object of therapeutic intervention. Zh Nevrol Psikhiatr Im S S Korsakova 113: 14-19.
75. Weller RA, Preskorn SH (1984) Psychotropic drugs and alcohol: pharmacokinetic and pharmacodynamic interactions. Psychosomatics 25: 301-309.
76. Mok PLH, Carr MJ, Guthrie B, Morales DR, Sheikh A, et al. (2024) Multiple adverse outcomes associated with antipsychotic use in people with dementia: population based matched cohort study. BMJ 385: e076268.
77. Jargin SV (2024) Alcohol and Alcoholism in Russia: An Update. J Addiction Prevention 12: 1-9.
78. Perelman MI, Safarov RN, Epshtein TV, Gorelik ES, Palei ME (1983) Hirurgicheskoe lechenie bolnyh tuberkulezom legkih i hronicheskim alkogolizmom (Surgical treatment of patients with pulmonary tuberculosis and chronic alcoholism). In: Priimak AA, ed. Sovremennyye metody hirurgicheskogo lechenia tuberkuleza legkih (Modern methods of surgical treatment of pulmonary tuberculosis). Collected works. Moscow: Institute of Tuberculosis 65-67.
79. Rudoy NM, Chubakov TC (1985) Tuberkulez legkih i alkogolizm (Pulmonary tuberculosis and alcoholism). Moscow: Meditsina.
80. Entin GM (1990) Lechenie alkogolizma (Treatment of alcoholism). Moscow: Meditsina.
81. Health Ministry of Ukrainian SSR (1987) Osobennosti vyvavleniya, diagnostiki, klinicheskogo techeniya, lecheniya i profilaktiki tuberkuleza u bolnyh hronicheskim alkogolizmom (Special features of detection, diagnosis, clinical course, treatment and prevention of tuberculosis in patients with chronic alcoholism). Methodical Recommendations. Kiev.

ISSN: 2330-2178

82. Health Ministry of Russian Federation (1998) Annex to the Order of the No. 140.
83. Krut'ko VS (1990) Pneumonia in patients with pulmonary tuberculosis and alcoholism. *Probl Tuberk* (1): 64-66.
84. Makhov VM, Abdullin RG, Gitel' EL, Zavodnov V Ia, Podzolkov VI, Sozinova Tiu, et al. (1996) Visceral lesions in alcoholism. *Ter Arkh* 68: 53-56.
85. Nikitin IuP (1990) *Profilaktika i lechenie alkogolizma* (Prevention and treatment of alcoholism). Kiev: Zdorov'ia.
86. Shabanov PD (2015) *Narkologia* (Narcology). 2nd edition. Moscow: Geotar-Media.
87. Livanov GA, Sofronov AG, Kalmanson ML, Tikhomirov S (2000) *Standarty narkologicheskoi pomoshchi* (Standards for narcological treatment). St. Petersburg: Mechnikov North-Western Medical University.
88. Vinnikova MA, Krenkel NT, Tikov MS, Tsareva IS (2018) *Sovremennye podhody k lecheniiu tiazhelogo alkogolnogo abstinentnogo sindroma. Metodicheskie rekomendacii* (Modern approaches to the treatment of severe alcohol withdrawal syndrome uidelines)). Moscow: Research and Practical Centre for Narcology.
89. Gromova OA, Torshin IYu (2018) *Magnii i "bolezni civilizacii"* (Magnesium and diseases of civilization). Moscow: Geotar-Media.
90. Abdullaev TYu, Utkin SI (2018) Different approaches to infusion therapy in alcohol addicted patients. *Voprosy Narkologii - Journal of Addiction Problems* 8: 54-75.
91. Jargin S, Robertson S (2025) Alcohol and alcoholism in Russia with special reference to toxicology. *J Environ Toxicol Res* 2: 119.
92. Dovzhenko AR, Artemchuk AF, Bolotova ZN, Vorob'eva TM, Manuilenko IuA (1988) Outpatient stress psychotherapy of patients with alcoholism. *Zh Nevropatol Psikhiatr Im S S Korsakova* 88: 94-97.
93. Lipgart NK, Goloburda AV, Ivanov VV Once more about AR (1991) Dobzhenko's method of stress psychotherapy in alcoholism. *Zh Nevropatol Psikhiatr Im S S Korsakova* 91: 133-134.
94. Voskresenskii VA (1990) Critical evaluation of ultra-rapid psychotherapy of alcoholism (concerning the article by A.R. Dovzhenko et al. "Ambulatory stress psychotherapy of alcoholics"). *Zh Nevropatol Psikhiatr Im S S Korsakova* 90: 130-132.
95. Mikirtichan GL, Kaurova TV, Pestereva EV (2022) *Vvedenie v bioetiku* [Introduction to bioethics]. St. Petersburg: Pediatric Medical University.
96. Jargin S (2015) Gilyarovskiy and Gannushkin psychiatric hospitals in Moscow. *Hektoen International Journal of Medical Humanities* 7.
97. Filashikhin VV, Avedisova AS, Kazakovtsev BA (2024) Analysis of the reasons for going to a private psychiatric clinic based on patient survey data. *Psikhicheskoe Zdravie - Mental Health* 19: 3-10.
98. Fulford KW, Smirnov AY, Snow E (1993) Concepts of disease and the abuse of psychiatry in the USSR. *Br J Psychiatry* 162: 801-810.
99. Snedkov EV (2013) *Shizofrenia i bredovyye rasstroystva* (Schizophrenia and delusional disorders). North-Western Medical University.
100. Shostakovich BV (1989) On social dangerousness of mental patients. *Schizophr Bull* 15: 555-558.
101. Jargin SV (2025) Over use of Surgery in Russia and Belarus: An Update. *J Surgery* 13: 10.