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Special Feature Article

Self-stigma among People with Gambling Problems

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Abstract

The DSM-5 and ICD-11 have classified gambling disorders as "addiction" or "dependence" in the same way as drug and alcohol use disorders. Medical care is now required to deal with people with gambling problems. However, people with gambling problems tend not to seek help, partly due to self-stigma, and most of them do not seek consultation. It would be desirable if they could seek help as soon as possible before they develop serious problems. In this paper I have described the medical, educational, and social perspectives. Providing treatment programs for gambling problems at medical institutions, public health centers, and mental health welfare centers may provide an opportunity for people with gambling problems to consult with medical providers and may improve the rate of continuation of treatment. In addition to the direct therapeutic effects of the program, it is also important to provide a safe place and to interact with supporters in a way that enhances self-efficacy and self-affirmation. Stigma reduction on the part of medical providers is also an important issue. This is based on the perspective of the "interpersonal distrustfulness theory". In school education, content about the harm of addiction and its dependency is not enough. It is also necessary to provide information on addiction as a mental health issue, and from the perspective of anti-stigma, to avoid discrimination against people with addiction. From 2022, high school students will be learning about mental illness in their health classes. In order to create a social environment where it is easy to consult about addiction issues, we would like to share

our "hardships of living (ikidurasa) Model" with students. From a social perspective, we introduced Mental Health First Aid and NIPPON COCORO ACTION as examples. These activities are designed to spread correct knowledge and understanding of mental health, to eliminate or reduce stigma in the community, and to encourage family and friends to help people with gambling-related problems to seek counseling and support. Efforts to reduce stigma and self-stigma in medicine, education, and society will also help prevent problem gambling. I hope that people with gambling problems will be able to receive counseling and support at an earlier stage.

Keywords: gambling disorder, addiction, self-stigma, hardships of living (ikidurasa), interpersonal distrustfulness theory

Introduction

The DSM-5 Diagnostic and Statistical Manual of Mental Disorders¹⁾ and 11th revision of the International Classification of Diseases (ICD-11) of the World Health Organization (WHO)²⁶⁾ classify gambling disorder as a so-called "addiction" or "dependency." In addition to the social situation, the problem of gambling has been attracting much attention. The Osaka Psychiatric Medical Center, where the author works (hereafter referred to as "our center"), has been working on addressing gambling disorder since 2014, when it was commissioned to establish and operate an addiction treatment center, and the number of patients seeking treatment intervention at the psychiatric department has increased.

However, there are still many patients who do not seek treatment, and one of the reasons for this is stigma, especially self-stigma (prejudice held by the patient against him-/herself). Efforts to reduce self-stigma will directly translate into prevention, which is expected to lead to earlier counseling and support for people with gambling disorder.

This paper first provides an overview of gambling disorder as a disease of self-stigma, followed by a discussion of measures that can be implemented by medical institutes, schools, and society to eliminate self-stigma in gambling disorder.

The clinical research included in this paper was approved by our ethical review committee for clinical research.

I. Gambling Disorder as Disease of Self-stigma

The lifetime prevalence of gambling disorder in Japan is estimated to be 3.6%, or about 3.2 million people.¹⁶⁾ However, in FY2017, 3,499 patients with gambling disorder received outpatient treatment at medical institutions nationwide, and 280 patients were hospitalized,¹⁰⁾ indicating that many people with gambling disorder do not receive medical care. Of course, the number of consultations at mental health welfare centers, public health centers, and other consultation organizations is increasing every year, and those with debt problems may consult legal experts such as lawyers and judicial scriveners. Some of them participate in self-help groups or consult private support groups. However, it has been shown in the U.S. that only 4% of those with gambling disorder consult a specialist,²⁰⁾ and they tend to seek professional support only when the problem becomes severe and serious.²²⁾ It is desirable to work toward recovery at an earlier stage, while the disease is still mild, but according to previous reports, the reasons for not seeking consultation include: “trying to handle the problem by oneself,” “feeling ashamed/prejudice,” “not wanting to admit there is a problem,” and “underestimating the problem.”³⁾⁵⁾²⁰⁾²³⁾ Thus, the public's negative evaluation of

people with gambling disorder and tendency to assume that “dependence and addiction are one's own responsibility,” or public stigma, are taken up by the people themselves and become self-stigma, making them conceal their gambling problem or avoid seeking help due to self-responsibility or a sense of shame. Even if a person with gambling disorder tries to fight back on his or her own, the possibility of suicide increases if the person is trapped due to relapse, etc. Gambling disorder is considered to have an aspect of being a disease of self-stigma.

Conversely, the most frequent occurrence that leads to consulting about gambling problems is when a serious crisis arises due to gambling, such as financial distress, problems in relationships, work or family, or legal problems.⁵⁾ Although family and friends can be a help-seeking trigger, very few people actually seek help from those close to them, and in most cases only after the problem has become severe.⁴⁾ In addition, there are cases in which the addiction checklist posted at gambling establishments is a trigger for consultation, but these cases are few compared with the above-mentioned triggers.⁵⁾

Thus, for the recovery of people with gambling disorders, it is necessary to eliminate the self-stigma problem, which is a factor inhibiting

consultations, and efforts to encourage people around them to promote intervention at an earlier stage are also required.

II. Treatment Programs in Self-help Groups and Medical Institutions

Gamblers Anonymous (GA) is a self-help group for people who want to quit gambling. The group conducts meetings and recovery programs based on the 12-step approach of Alcoholics Anonymous (AA), a self-help group for alcoholics. The one-year continuation rate for GA alone is only 7.5%,²¹⁾ and the prognosis for many people with gambling disorder is unknown. Although GA has been shown to be effective in more severe cases of gambling disorder,¹⁷⁾ it tends to be avoided by some people because it is aimed at the complete cessation of gambling.

In addition, self-help groups themselves are not well-known to the general public. According to a survey conducted by Sakai City in 2020, "Survey on Awareness of Alcohol, Drugs, Gambling, and Online Games,"¹⁹⁾ only 17.9% of the general public were aware of self-help groups. Poor awareness and lack of knowledge of self-help groups may also be factors determining the lack of support, and improving awareness is also an issue.

Standard treatment programs for gambling disorder have been developed

at medical institutions.¹⁶⁾ A study by Matsushita et al. found that 42.6% of an intervention group who joined the program remained abstinent from gambling 6 months later, while only 2.2% of a non-intervention group remained abstinent.¹⁶⁾ In addition, the frequency of gambling and amount of money spent decreased in the intervention compared with non-intervention group.

Patients were divided into two groups: those who participated at least once in GAMP (Gambling Addiction Meeting Program) and those who did not participate. Treatment continuation rates six months after the initial visit were 75% in the GAMP-participating group and 16.7% in the non-participating group.⁶⁾ Specialized treatment programs for gambling disorder, such as GAMP, may be a useful tool to help patients get through the treatment initiation period when they are most likely to discontinue treatment.

According to Petry, N.M., the effectiveness of treatment for gambling disorder is improved by combining specialized medical treatment with self-help groups.¹⁷⁾¹⁸⁾ The two-month cessation rate of gambling is 36% with specialized treatment alone, but 48% with self-help groups. The treatment dropout rate is also low.¹⁷⁾

One of the factors increasing the effectiveness of treatment is for

supporters to build a good relationship with addicts²⁵⁾; therefore, it is important for specialized programs to also change the awareness of supporters and have an effect from an anti-stigma perspective.²⁴⁾²⁵⁾ In our center, medical staff members are trained in cognitive-behavioral therapy and make efforts to nurture a relationship and create an environment in which the patient can feel comfortable talking with the therapist. We place as much emphasis as possible on the patient's own independent thinking, and strive to nurture a collaborative relationship between medical staff and the patient. For example, the treatment program is designed to promote the patient's sense of self-efficacy and -affirmation, and provide an opportunity for the patient to express such comments as: "I felt like I could manage," and "It is good to know that I am doing some things."

The perspective of "interpersonal distrustfulness"⁹⁾ is also important when treating and supporting addicts. The "interpersonal distrustfulness theory,"⁹⁾ which states that "addicts cannot trust 'people,' but only 'things' such as alcohol and drugs, and 'independent activities' such as gambling and shopping," defines addiction as "a basic distrust of others that prevents them from seeking help appropriately from those around them, and they try to cope with their negative

feelings alone.⁹⁾ Addicts have not only the problem of dependence on the surface, but also various underlying hardships of living (*ikidurasa*) and psychological isolation. Therefore, uniformly connecting patients to group therapy or self-help groups may actually hinder recovery, especially patients with interpersonal distrustfulness, where the first priority is to work on restoring trust in others in one-on-one consultation and treatment situations.

III. Preventive Education and "Ikidurasa Model"

The following section will address what is required in school education.

Currently, the targets of efforts by medical care and self-help groups, as well as consultations at mental health welfare and public health centers, are those who are already seriously ill and whose problems have become more serious, or in the case of the prevention classification by Caplan, G.,²⁾ those in the tertiary prevention category. Primary and secondary prevention measures are not yet sufficient. One of the most notable primary prevention efforts is preventive education in schools.

In addition to health and physical education teachers, school nurses, and other instructors, outside lecturers from the police, judiciary, and mental health

and welfare fields are sometimes in charge of preventive education at schools. In educational settings, addiction is often treated as a problem of substance abuse, and under the so-called “big no-no” policy, the focus is on teaching about the harms of addictive substances and addiction, and there has not been sufficient provision of information on mental health issues. In the revised curriculum guidelines for 2022, the section on “Prevention and Recovery from Mental Illness” was added to the “Contemporary Society and Health” section of high school health and physical education for the first time in about 40 years. The revised guidelines include instruction in the prevention and recovery of mental illness “so that students can understand that early detection of mental and physical disorders, and early initiation of treatment and support will increase the possibility of recovery.” In “Commentary on the Courses of Study for Senior High Schools,”¹⁴⁾ it is written that “In addition to addictions to substances such as alcohol and drugs, excessive participation in activities such as gambling can develop into addictive behavior if it becomes habitual, and it is important to mention that this can have a negative impact on daily life. In addition to the harm and addictive properties, it is also important to “enable people to understand mental

illness correctly, consult with specialists, and understand that it is important to create a social environment that facilitates early treatment, and that people with mental illnesses are not the target of prejudice or discrimination.”

In reality, however, it is important how to provide preventive education. For reference, the left column of Table 1 shows examples of comments from students at a lecture on preventive education for gambling and other addictions at a high school in Osaka Prefecture, which the author has conducted in the past according to the “big no-no” model. The students' impressions were given as negative words such as “scary,” “no good,” and “difficult,” as well as “I'm fine” and “I don't want to get involved,” as if they were dealing with something alien to them. Although they may have understood the harm and addictive nature of gambling, it can be said that the purpose of preventive education has not been achieved in terms of “correct understanding” and “dealing with mental illness.” The content that the author believes should be conveyed in preventive education is shown in Table 2. The author calls preventive education that takes account of these contents the “hardships of living (ikidurasa) model” in contrast to the conventional “big no-no” model. When preventive education was conducted with this model in mind,

the feedback from students was as shown in the right column of Table 1, and it was very different from the “big no-no” model (of course, there were also comments, such as: “addiction is terrible” and “let's definitely not get involved”, but these were in the minority). Many of the comments received from “ikidurasa model”-based preventive education were about reflecting on one's own stress management, emotional regulation, and seeking consultation and support, aiming for a change in awareness and behavior (Table 1, right column). This model will help to convey more accurate information about “dealing with mental illness” as described in the “Commentary on the Courses of Study for Senior High Schools,” and it is considered that implementing this kind of preventive education will help to create a social environment in which it is easier to seek counseling and support.

IV. What Society Can Do for Early Intervention

Finally, how society can be involved will be addressed.

There are few opportunities for people with gambling problems to receive encouragement from their families or other people close to them to seek help. Although they may say things like: “Do something about it,” “It can't go on like this,” “Be more aware of what you're

doing,” or “Get your act together,” lacking in any real sense of concrete action, most people with gambling disorder have never received simple, concrete messages like: “Let's talk about it” or “Let's go to a self-help group.” This is due to the lack of awareness of self-help groups and tendency to attribute gambling disorder to self-responsibility or personality problems, etc. To promote early intervention for persons with gambling disorder, it is necessary to provide educational opportunities so that those close to them can recognize warning signs and offer support.

CRAFT (Community Reinforcement and Family Training)¹³⁾ was introduced to Japan, and is now being provided more and more as a tool to support families. In family classes, messages such as: “to connect the addicted person to treatment” and “the family itself must change” are often emphasized, but CRAFT always aims at the beginning: “to make the family comfortable”, “so that the family does not have to suppress their feelings and endure.” Since family members are often exhausted from dealing with addicts, the perspective of family self-care should also be emphasized.

One method for promoting outreach by family and friends is Mental Health First Aid (MHFA),⁸⁾¹²⁾ which was developed in Australia in 2001. MHFA is a training program that teaches

members of the general public about mental health and how to provide initial support. The aim of this program is to enable people to provide appropriate initial support by recognizing when a close friend is experiencing mental health problems, approaching them, providing them with information, and connecting them with support. The program covers understanding and responding to persons in mental health crises such as depression, anxiety, psychosis, substance use disorders, eating disorders, and gambling problems, as well as responding to crisis situations such as suicide, self-harm, panic attacks, and aggressive behavior. Evidence is accumulating, including positive changes in school education regarding knowledge of mental disorders, stigma, and confidence in providing support,⁷⁾ and the effects on nurses and residents in Japan.¹⁵⁾

Based on the MHFA approach, the Ministry of Health, Labour and Welfare is creating a system in which people close to those with mental health issues can support them as “Cocoro Supporters (mental health supporters).” The Cocoro Supporter does not require any specific qualifications or specialized knowledge, providing support mainly through listening to family members and coworkers. The program is aimed at people of all ages, from elementary school children to the elderly, and the

ministry aims to train one million people by the end of fiscal 2033. By spreading accurate knowledge and understanding of mental health, reducing discrimination and prejudice (stigma), and creating an environment where people suffering from mental health problems can easily talk about their problems, it aims to help with early detection and support, and create a society where everyone can live comfortably and authentically, regardless of whether they have a mental disorder and the severity of the disorder if present.

Every year, May 14 to 20 is Gambling and Other Addiction Awareness Week, and November 10 to 16 is Alcohol-Related Problems Awareness Week. However, according to a Sakai City survey,¹⁹⁾ rates of awareness of these weeks are 0.9 and 1.4%, respectively, indicating that they are little known to the general public, despite various efforts being made throughout Japan. In addition, October 10 of every year is “World Mental Health Day,” which was established by the World Federation for Mental Health (WFMH) in 1992 to raise public awareness and interest in mental health issues, to eliminate prejudice, and spread accurate knowledge. It is an official international day, supported by the World Health Organization (WHO), and society is expected to make better use of CRAFT, MHFA, Cocoro

Supporters, awareness weeks, and memorial days to spread accurate knowledge and understanding of mental health issues and reduce stigma.

Conclusion

Due to the influence of self-stigma, people with gambling disorder tend to avoid seeking support, and most of them do not seek counseling. When they do finally seek help, it is only after they have become seriously ill and are facing marked problems, so it is desirable to work on their recovery at an earlier stage. What is important for this is “elimination and reduction of stigma in society” and “encouragement from those close to the patient.”

This paper presents efforts from a medical perspective, preventive education in schools, and approaches to society.

It is hoped that efforts to reduce self-stigma will directly lead to prevention, and that people with gambling disorder will seek counseling and support at an earlier stage.

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References

- 1) American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th ed (DSM-5). American Psychiatric Publishing, Arlington, 2013 (日本精神神経学会 日本語版用語監修, 高橋三郎, 大野 裕監訳: DSM-5 精神疾患の診断・統計マニュアル. 医学書院, 東京, 2014)
- 2) Caplan, G.: Principles of Preventive Psychiatry. Basic Books, New York, 1964
- 3) Gainsbury, S., Hing, N., Suhonen, N.: Professional help-seeking for gambling problems: awareness, barriers and motivators for treatment. *J Gambl Stud*, 30 (2); 503-519, 2014
- 4) Hare, S.: A Study of Gambling in Victoria: Problem Gambling from a Public Health Perspective. Department of Justice, Melbourne, 2009
- 5) Hing, N., Nuske, E., Gainsbury, S.: Gamblers At-risk and their Help-seeking Behaviour, Gambling Research Australia, Melbourne, 2011

- (https://www.responsiblegambling.nsw.gov.au/__data/assets/pdf_file/0006/8803/77/Gamblers-at-risk-and-their-help-seeking-behaviour.pdf) (参照 2021-11-30)
- 6) 入来晃久, 中林大二, 田中さやかほか: ギャンブル障害は集団療法で回復へつながらるか—2年後追跡調査—. 大阪精神医療センター紀要, 24; 1-8, 2019
- 7) Jorm, A. F., Kitchener, B. A., Sawyer, M. G., et al.: Mental health first aid training for high school teachers: a cluster randomized trial. *BMC Psychiatry*, 10; 51, 2010
- 8) Kitchener, B., Jorm, A., Kelly, C. (メンタルヘルス・ファーストエイド・ジャパン訳): メンタルヘルス・ファーストエイド—こころの応急処置マニュアルとその活用— (大塚耕太郎, 加藤隆弘ほか編). 創元社, 大阪, 2021
- 9) 小林桜児: 人を信じられない病—信頼障害としてのアディクション—. 日本評論社, 東京, p.73-75, 2016
- 10) 国立精神・神経医療研究センター: 精神保健福祉資料. (<https://www.ncnp.go.jp/nimh/seisaku/d-ata/>) (参照 2021-11-30)
- 11) 厚生労働省: NIPPON COCORO ACTION. (<https://cocoroaction.jp/>) (参照 2021-11-30)
- 12) Mental Health First Aid Australia: Helping Someone with Gambling Problems: Mental Health First Aid Guidelines. Mental Health First Aid Australia, Melbourne. 2015 (http://www.mhfa.com.au/sites/default/files/MHFA_Gambling.pdf) (参照 2021-11-30)
- 13) Meyers, R. J., Wolfe, B. L (松本俊彦, 吉田精次監訳, 渋谷繭子): CRAFT—依存症者家族のための対応ハンドブック—. 金剛出版, 東京, 2013
- 14) 文部科学省: 高等学校学習指導要領解説保健体育編 体育編. p.203, 2018 (http://www.mext.go.jp/a_menu/shotou/new-cs/1407074.htm) (参照 2021-11-30)
- 15) Nakagami, Y., Kubo, H., Katsuki, R., et al.: Development of a 2-h suicide prevention program for medical staff including nurses and medical residents: a two-center pilot trial. *J Affect Disord*, 225; 569-576, 2018
- 16) 日本医療研究開発機構障害者対策総合研究開発事業「ギャンブル障害の疫学調査, 生物学的評価, 医療・福祉・社会的支援のありかたについての研究」(研究代表者: 松下幸生). 2016~2018
- 17) Petry, N. M.: Patterns and correlates of Gamblers Anonymous attendance in pathological gamblers

seeking professional treatment. *Addict Behav*, 28 (6); 1049-1062, 2003

18) Petry, N. M., Ammerman, Y., Bohl, J., et al.: Cognitive-behavioral therapy for pathological gamblers. *J Consult Clin Psychol*, 74 (3); 555-567, 2006

19) 堺市: 「お酒, くすり, ギャンブル等, インターネット・ゲームに関する意識行動調査」調査結果(速報).

(https://www.city.sakai.lg.jp/shisei/gyosei/shingikai/kenkofukushikyoku/kenkobu/izon_konwakai/r2kaisai/73787820210510151651714.files/siryoku4-1.pdf) (参照 2021-11-30)

20) Slutske, W. S.: Natural recovery and treatment-seeking in pathological gambling: results of two U. S. national surveys. *Am J Psychiatry*, 163 (2); 297-302, 2006

21) Stewart, R. M., Brown, R. I.: An outcome study of Gamblers Anonymous. *Br J Psychiatry*, 152 (2); 284-288, 1988

22) Suurvali, H., Cordingley, J., Hodgins, D. C., et al.: Barriers to

seeking help for gambling problems: a review of the empirical literature. *J Gambl Stud*, 25 (3); 407-424, 2009

23) Suurvali, H., Hodgins, D. C., Cunningham, J. A.: Motivators for resolving or seeking help for gambling problems: a review of the empirical literature. *J Gambl Stud*, 26 (1); 1-33, 2010

24) 高野 歩, 川上憲人, 宮本有紀ほか: 物質使用障害患者に対する認知行動療法プログラムを提供する医療従事者の態度の変化. *日本アルコール・薬物医学会雑誌*, 49 (1); 28-38, 2014

25) 谷合知子, 四辻直美, 奥田秀実ほか: 薬物等再発予防プログラム「TAMARPP」の質的効果評価—担当職員の振り返りから—。 *日本アルコール・薬物医学会雑誌*, 49 (6); 305-317, 2014

26) World Health Organization: International Classification of Diseases 11th Revision (ICD-11). (<https://icd.who.int/>) (参照 2021-11-30)

表 1 生徒からの感想

従来のダメ絶対モデル	生きづらさモデル
依存症は怖いとわかった	人に相談するのは苦手だけど、話せる人を作ろう
ならないように気をつけようと思う	縁遠いと思っていたが身近な人になるかもしれない
依存症になるものには近づかない	友達はあるけど孤独感は消えない
自分はダメな奴だというように相談はできない	安心して人に頼れていないのはある
自分も少し依存症が思いあたるので気をつけたい	人を信じたいけど信じられない、どうしたらいいか
絶対に依存しない	一人で抱え込まないようにしようと思った
友達の誘いでも受け入れず断ろうと改めて思った	相談したり、感情を適切に扱うことが大変重要
依存症を治すのは難しいと思った	仲間のすごさが改めてよくわかった
とても危ない病だと思いました	意志の弱い非人格者と思っていた
手を出したらいけないなと思いました	親身になって治療するという視点を得た
やらなければ依存しないので、しないようにする	自分も誰かの依存先の1つになって助けられたら
ギャンブルは覚せい剤と同じ、大麻は少しマシ	人は一人で生きてゆけないのだなと改めて思った
すべてほどほどにしないとイケない	無意識に人に頼らないようにしていたことに気づいた
1回でもやるとダメなので、絶対にやらない	人とのかわりが大事だと思った

Table 1: Feedback from students

Traditional “big no-no” model:

I now know that addiction is scary

I will be careful not to become addicted

I will stay away from things that make me addicted

I can't ask for advice because it would be like announcing that I'm a bad person

I want to be careful because I can think of a few addictions myself

I will never be addicted

I thought again that I should not even accept an invitation from a friend and refuse it

I thought that it is difficult to cure addiction

I think it is a very dangerous disease

I should not get involved with it

If I don't do it, I won't be dependent on it, so I won't do it

Gambling is the same as using stimulants. Marijuana is a little better

Everything must be done in moderation

It only takes one time to ruin it, so I never do it

Hardships of living (ikidurasa) model:

I am not good at talking to people, but I will meet someone I can talk to

I thought it was a problem I couldn't relate to, but someone close to me might become one

I have friends, but the loneliness won't go away

I can't rely on others with peace of mind
 I want to trust people, but I can't. What should I do?
 I try not to keep it all to myself
 It is very important to talk to others and handle my feelings appropriately
 I realized how great my friends are
 I thought I was a weak-willed impersonal person
 I gained the perspective of treating people with kindness
 I wish I could be one of the people on whom someone else depends and help them
 I realized once again that people cannot live alone
 I realized that I had unconsciously tried not to depend on others
 I realized how important it is to be involved with others

表2 すべての生徒に伝えたい「生きづらさモデル」

・ノーマライゼーション	・孤独の病
・誰でもなる可能性がある	・孤立化しやすい
・生きづらさを抱えている	・支援につながること
・うまく対処できない	・回復できる
・ピンチな状態の表現型の1つ	・家族だけでも相談できる
・自己治療仮説	・信頼障害仮説

Table 2: “Hardships of living (ikidurasa) model” that I want to convey to all students

- ・Normalization
- ・Everyone has the potential to be
- ・I have “ikidurasa”
- ・Can't cope well
- ・One of the phenotypes of being in a pinch
- ・Self-treatment hypothesis
- ・Isolated illness
- ・Can be isolated easily
- ・Can lead to support
- ・Can recover
- ・Can talk with family members alone
- ・Interpersonal distrustfulness theory