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Indirect self-destructiveness in women with schizophrenia

Autodestruktywność pośrednia u kobiet ze schizofrenią

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Abstract

Background: Many authors emphasise the influence of gender differences on mental health and the course and experience of mental illness, and/or postulate a gendered perspective in mental health research. Research holistically considering indirect self-destructiveness in women with schizophrenia is hard to find in the international literature; studies have been performed on the sole basis of some discrete manifestations of indirect self-destructiveness. **Aim:** The aim of this study was to explore the indirect self-destructiveness syndrome and its categories in women with schizophrenia. **Method:** A group of 125 women with paranoid schizophrenia, aged 27–57, were examined by using the Polish version of the Chronic Self-Destructiveness Scale (CS-DS); for comparison, a group of 175 men with schizophrenia and a sociodemographically well-matched group of 125 healthy women were examined. **Results:** The intensity of indirect self-destructiveness and most of its categories were found to be greater in the group of women with schizophrenia compared to men with schizophrenia (transgression, poor health maintenance, personal and social neglects) and healthy women (transgression, personal and social neglects, lack of planfulness, helplessness). Nevertheless, women with schizophrenia displayed signs of better psychosocial adjustment than schizophrenic men. **Conclusions:** Comprehensive therapeutic, i.e. psychiatric, psychological and social, interventions should serve to enhance the "self" defence and self-care functions, and improve the evaluation of adequacy and efficiency in women with schizophrenia. Working with such patients towards increasing their life satisfaction, although life did not spare them suffering, seems to be equally important in (psycho) therapy. The mobilisation and orientation of their actions towards those in favour of their development and health appear as crucial.

Keywords: indirect self-destructiveness, schizophrenia, women

Streszczenie

Wstęp: Wielu autorów podkreśla wpływ różnic płciowych/rodzajowych na zdrowie psychiczne oraz na przebieg i doświadczanie choroby psychicznej i/lub postuluje rodzajową perspektywę w badaniach nad zdrowiem psychicznym. W międzynarodowej literaturze trudno znaleźć badania w sposób holistyczny traktujące autodestruktywność pośrednią u kobiet chorych na schizofrenią; badania zrealizowano jedynie nad niektórymi pojedynczymi przejawami autodestruktywności pośredniej. **Cel:** Celem niniejszej pracy było zbadanie syndromu autodestruktywności pośredniej i jej kategorii u kobiet chorych na schizofrenię. **Metoda:** Grupa 125 kobiet ze schizofrenią paranoidalną, w wieku 27–57 lat, została zbadana za pomocą polskiej wersji Chronic Self-Destructiveness Scale (CS-DS); dla porównania zostały zbadane grupa 175 mężczyzn chorych na schizofrenię i dobrze dopasowana pod względem socjodemograficznym grupa 125 kobiet zdrowych. **Wyniki:** Stwierdzono, że intensywność autodestruktywności pośredniej i większości jej kategorii była większa w grupie kobiet ze schizofrenią w porównaniu z mężczyznami ze schizofrenią (transgresja, zaniedbania zdrowotne, zaniedbania osobiste i społeczne) i ze zdrowymi kobietami (transgresja, zaniedbania osobiste i społeczne, brak planowania, bezradność). Niemniej kobiety chore na schizofrenię wykazały przejawy lepszego przystosowania psychospołecznego niż mężczyźni chorzy na schizofrenię. **Wnioski:** Kompleksowe działania terapeutyczne powinny zmierzać do wzmocnienia ochrony „ja" i funkcji samoopiekuńczych oraz do poprawienia oceny adekwatności i skuteczności u kobiet chorych na schizofrenię. Praca z tymi pacjentkami w kierunku zwiększenia satysfakcji z życia – choć życie to nie szczędziło im cierpień – wydaje się równie ważna w (psycho)terapii. Istotna jest również mobilizacja i orientacja aktywności w kierunku działań sprzyjających ich rozwojowi i zdrowiu.

Słowa kluczowe: autodestruktywność pośrednia, schizofrenia, kobiety

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BACKGROUND

Self-destructive behaviours refer to behaviours harmful to the person, irrespective of the intention, objective and degree of awareness of their adverse consequences, the time perspective (i.e. immediate vs. delayed harm) and object of harm (the person's physical or psychological existence). Until lately, the term "self-destructiveness" was mainly (if not solely) understood as direct self-destructiveness, manifested by self-mutilations, self-inflicted injuries, and attempted or committed suicides. Nevertheless, for some time now another category of self-harm has been differentiated, i.e. indirect or chronic self-destructiveness (Kelley et al., 1985; Suchańska, 1998).

The category seems to be worth discussing, as it almost imperceptibly produces undesired and harmful effects because its numerous behaviours are considered normal by the majority. Whereas the problem of directly self-destructive behaviours is obvious and open to no doubt, less acute and more "subtle" forms of self-harm or compromising one's quality of life and/or shortening one's life span are not immediately and directly perceptible (for instance, risky behaviours, addictions, neglects etc.). They usually draw less attention, particularly as many of them are treated as common (or at least typical), hence "normal" ones.

Chronic self-destructiveness is defined as behaviours involving a generalised tendency to engage in acts that increase the likelihood of experiencing negative future consequences and/or decrease the probability of achieving positive future ones (Kelley et al., 1985). For the purpose of this study, indirect/chronic self-destructiveness was assumed to include behaviours entailing a probable negative effect intermediated by additional factors with the association between the behaviour and harm perceived as likely. Therefore, indirect self-destructiveness comprises both taking and giving up (commission or omission of) specific actions: getting into dangerous and high-risk situations (active form) or neglecting one's safety or health (passive form) (Suchańska, 1998, 2001).

There are several categories of indirectly self-destructive behaviours, including transgression and risk, poor health maintenance, personal and social neglects, lack of planfulness, and helplessness and passiveness when facing problems/difficulties. Transgression and risk refer to behaviours violating social norms, such as school rules or principles of conduct in the community, and risky behaviours undertaken for fleeting pleasure. Poor health maintenance comprises behaviours that are harmful to one's health, such as excessive eating or drinking, missing medical appointments or not complying with physicians' recommendations. Personal and social neglects encompass, for example, neglecting one's duties or affairs (personally and interpersonally) important to the individual. Lack of planfulness involves acting mainly on impulse, without much consideration. Helplessness and passiveness are abandoning or failing to take an action in circumstances where such an action might put an end to distress or avert danger (Kelley et al., 1985; Suchańska, 1998, 2001).

Research on indirect or chronic self-destructiveness has focused mainly (if not exclusively) on mentally healthy people; indirectly self-destructive behaviours, however, are present not only in healthy individuals, but also among those who suffer from mental diseases. In the case of the latter, indirectly self-destructive behaviours may involve (or alternate with) psychotic symptoms or syndromes.

Research has shown that the psychotic process (schizophrenia) increases indirectly self-destructive tendencies in patients, compared to healthy individuals (Tsirigotis, 2018).

Some authors emphasise the influence of gender differences on mental health and the course and experience of mental illness, and/or postulate a gendered perspective in mental health research, comprising gendered risk factors such as intimate partner violence (Chandra et al., 2019; Howard et al., 2017; Judd et al., 2009), whereas others claim that research findings on sex/gender differences in the psychopathology of psychoses often lack consistency (cf. Rosen et al., 2020).

Research holistically considering indirect self-destructiveness in women with schizophrenia is hard to find in the international literature; as mentioned above, studies have been performed on the sole basis of some discrete manifestations of indirect self-destructiveness.

Thus, the aim of this study is to explore indirect self-destructiveness as a generalised behavioural tendency and its categories in women suffering from schizophrenia.

Therefore, it has been assumed that the intensiveness of indirect self-destructiveness, as a generalised tendency and its categories, in women with schizophrenia differs from those in schizophrenic men and healthy women.

METHOD

The present study is part of a series of research projects on indirect self-destructiveness in patients with schizophrenia, hence the methods used and some fragments may bear similarity to those presented in earlier published papers (Tsirigotis, 2018; Tsirigotis et al., 2016).

The approval of the Bioethics Committee of the University was obtained before initiating the study. The Helsinki Declaration recommendations were followed. The survey was anonymous, with voluntary participation preceded by obtaining informed consent of the subjects.

Participants

For the purpose of achieving the research objective, a group of 300 patients (125 women, 175 men) with paranoid schizophrenia (diagnosed according to the International Statistical Classification of Diseases and Related Health Problems, 10th revision, ICD-10 criteria), aged 27–57 years (mean age: 36.23 years), was studied. The patients were clinically stable, in remission, had not been hospitalised for the prior 12 months,

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Variable		Women		Men		Significance
		n	**%**	***n***	**%**	***p***
		125	41.67	175	58.33	0.004
Age	Mean ± *SD*	36.20 ± 5.06		36.25 ± 6.68		ns.
	Range	27–56		25–57		
Educational level	Elementary	33	26.40	18	10.29	0.0003
	Vocational	26	20.80	53	30.29	ns.
	Secondary	40	32.00	93	53.14	0.0003
	University	26	20.80	11	6.28	$p < 0.0000$
Marital status	Married	63	50.40	53	30.29	0.0004
	Divorced	13	10.40	11	6.28	0.0000
	Single	31	24.80	111	63.43	0.0000
	Widow/er	18	14.40	0	0	$p < 0.0000$
Residency	Urban	110	88.00	126	72.00	0.0009
	Rural	15	12.00	49	28.00	0.0009
Source of income	Disability pension	112	89.60	147	84.00	ns.
	Work	13	10.40	13	7.43	$p < 0.0000$
	Maintained by family	-	0	15	8.57	$p < 0.0000$
Sense of support	Yes	114	91.20	86	49.14	$p < 0.0000$
	No	11	8.80	89	50.86	$p < 0.0000$

Tab. 1. Characteristics of participating groups

and had been on the same medication for at least 6 months. Thus, none of the patients was acutely unwell or in relapse, and all of them were in at least partial remission, which facilitated conducting the study. The patients were diagnosed by experienced psychiatrists and recruited at mental health centres. They were treated with second-generation or atypical antipsychotics. The female control group comprised 125 healthy women and was well sociodemographically matched; they did not report any family history of schizophrenia. The characteristics of the women and men with schizophrenia are presented in Tab. 1.

Exclusion criteria for the schizophrenia group were relapse and double diagnosis, while those for the control group were substance (narcotics) use and psychological and/or psychiatric assistance determined on the basis of observation, clinical interview, and self-report on a sociodemographic sheet.

The examinations were anonymous, with voluntary participation preceded by obtaining the subjects' informed consent. An experienced clinical psychologist and psychotherapist examined the patients and the control group by applying the Chronic Self-Destructiveness Scale (CS-DS) and a sociodemographic sheet.

Measures

The assessment of indirect (chronic) self-destructiveness employed the Polish version of the CS-DS by Kelley, as adapted by Suchańska (1998). In order to examine chronic self-destructiveness as a generalised tendency, Kelley developed a research instrument to elicit information concerning groups or categories of behaviours including carelessness, poor health maintenance, evidence of transgression, and lack of planfulness. The final version of the tool consists of a Likert-type internally consistent set of 52 items; the total score indicates the intensity of indirect self-destructiveness (Kelley et al., 1985). The Polish version of the scale, as well as the original one, is characterised by high reliability (Cronbach's alpha, a: 0.811) and validity (0.823), and includes the following (sub)scales: Transgression and Risk (A1; e.g. I like jobs with an element of risk; I have done dangerous things just for the thrill of it; Lots of laws seem made to be broken), Poor Health Maintenance (A2; e.g. I am familiar with basic first-aid practices), Personal and Social Neglects (A3; e.g. I usually meet deadlines with no trouble), Lack of Planfulness (A4; e.g. I seldom have even minor accidents or injuries), and Helplessness and Passiveness in the face of difficulties (A5; e.g. Sometimes I don't seem to care what happens to me). CS-DS scores between 52 and 104 are considered low, 105–160 – moderate, and 161–260 – high (Suchańska, 1998).

Statistical analysis

The statistical analysis of the results employed descriptive and statistical inference methods. The mean values of quantitative traits were described using the arithmetic mean (*M*), while the standard deviation (*SD*) was applied as the dispersion measure. Due to the size of the study groups (>100) and the limit theorems, Student's *t*-test was used for testing differences. The maximum acceptable type I error was assumed at $\alpha = 0.05$ for all analyses. Asymptotic two-sided test probability p was calculated, and $p \leq 0.05$ was considered statistically significant. The software tool used for statistical analyses was the Statistica PL 13.3 for Windows (StatSoft Polska, 2015) statistical package. Raw scores

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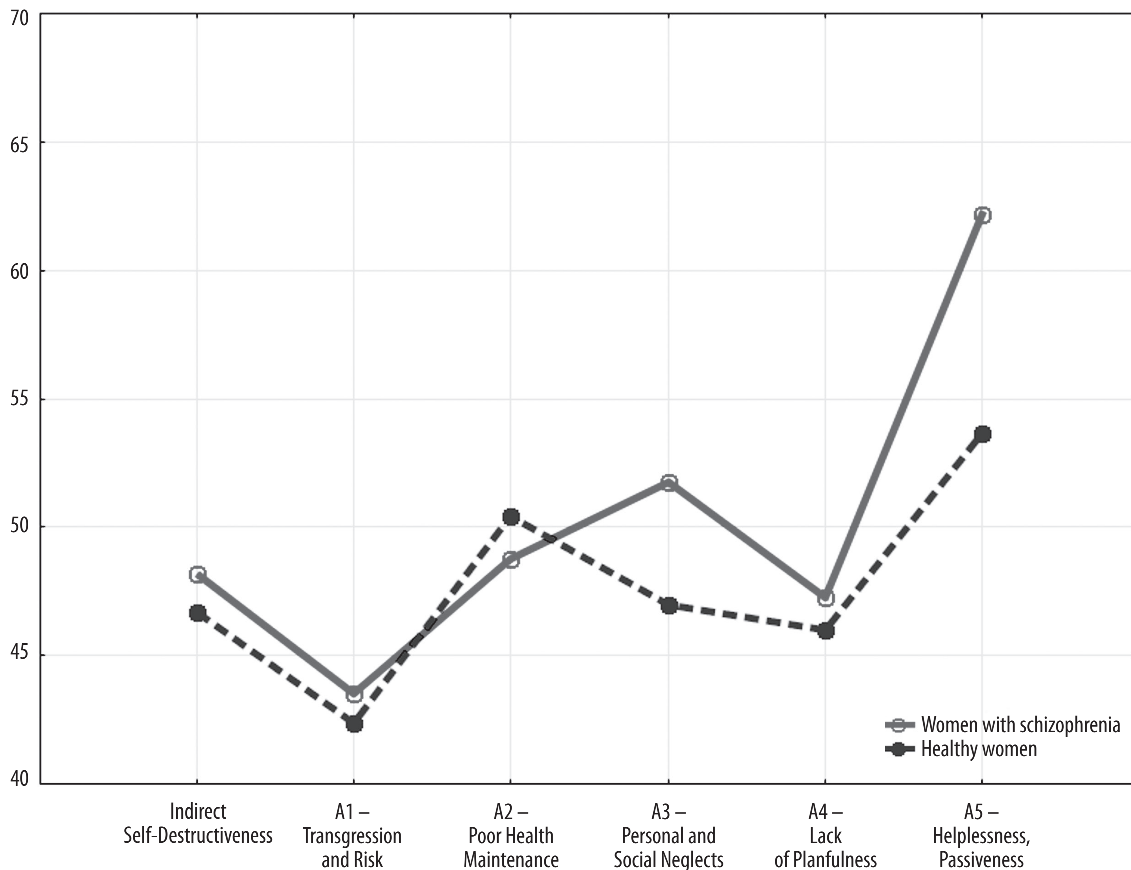

Fig. 1. Profiles of women with schizophrenia and healthy women in CS-DS

CS-DS subscales	Schizophrenia		Healthy women		Significance	
	M	*SD*	*M*	*SD*	*t*	*p*
INDIRECT SELF-DESTRUCTIVENESS	125.625	25.093	120.301	15.585	2.735	0.005
A1 – Transgression and Risk	39.313	11.047	38.502	7.679	2.524	0.05
A2 – Poor Health Maintenance	26.812	6.229	28.796	5.182	2.159	0.05
A3 – Personal and Social Neglects	31.063	8.511	27.316	4.740	2.550	0.01
A4 – Lack of Planfulness	19.031	4.728	17.531	4.115	2.658	0.05
A5 – Helplessness, Passiveness	9.438	2.917	7.235	1.217	2.964	0.003

Tab. 2. Comparisons of CS-DS scores in women with schizophrenia and healthy women

achieved by the subjects were converted into standardised ones (ten scale, T units to enable inter-profile comparisons).

RESULTS

Tab. 1 shows the sociodemographic characteristics of the subjects suffering from schizophrenia. The population distribution was rather consistent, with the recent epidemiological studies reporting a slightly higher incidence of schizophrenia in men compared to women (Riecher-Rössler et al., 2018). As shown in the table, most studied women had secondary education (32.00%), were married (50.40%), and lived in cities (88.00%). In turn, a majority of men also had secondary education (53.16%) and were urban residents (72.00), but were single (63.43%). A vast majority of women (91.20%), i.e. almost twice as many as men (49.14%), declared that they felt they had social support. None of the women were maintained by their family, while as many as 8.57% of men were.

Tab. 2 and Fig. 1 compare the scores (*M*, *SD*) of women with schizophrenia and healthy controls. As can be noticed, the scores differ statistically significantly, too. Women with schizophrenia achieved significantly higher scores than healthy controls on almost all CS-DS indices/(sub)scales: Indirect Self-Destructiveness (global index), A1 (Transgression and Risk), A3 (Personal and Social Neglects), A4 (Lack of Planfulness) and A5 (Helplessness, Passiveness); they achieved lower scores than healthy women solely on A2 (Poor Health Maintenance).

Tab. 3 and Fig. 2 compare the scores (*M*, *SD*) obtained by women and men with schizophrenia on particular CS-DS indices. As can be seen, women had significantly higher

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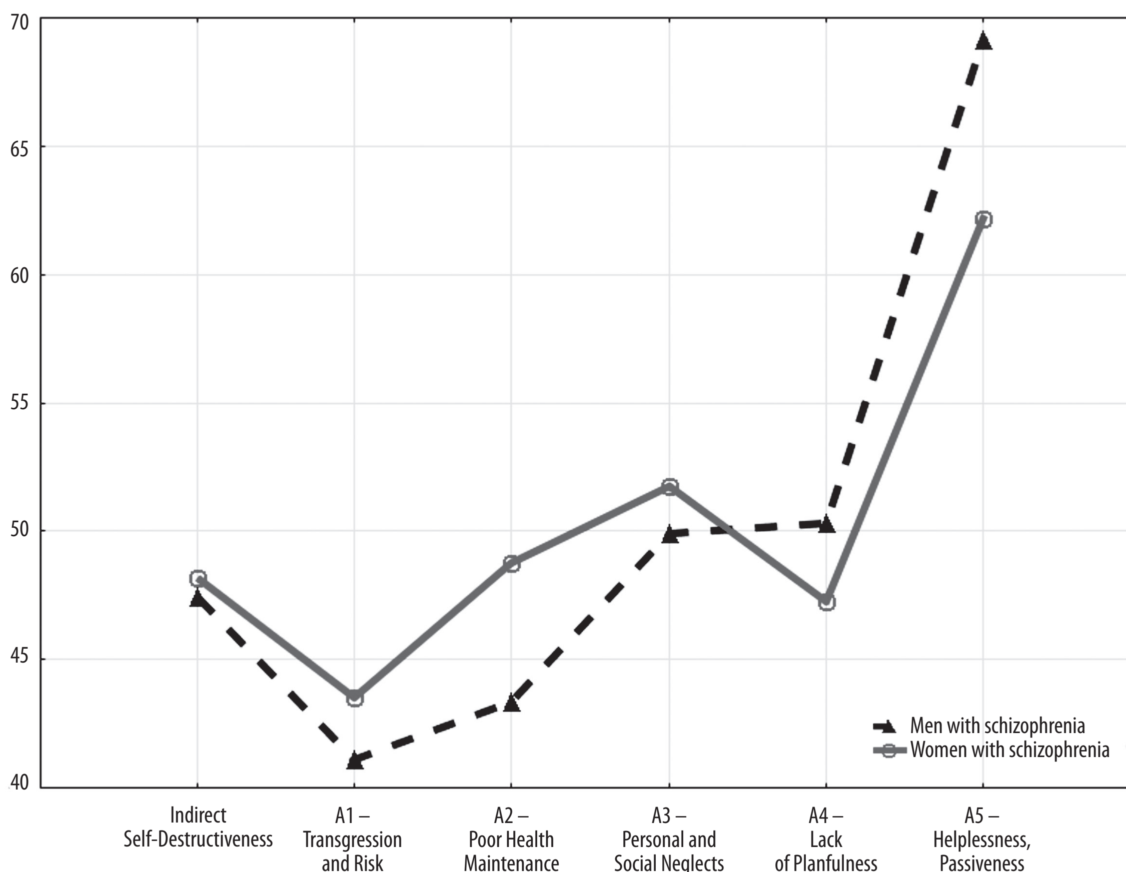

Fig. 2. Profiles of women and men with schizophrenia in CS-DS

CS-DS subscales	Women		Men		Significance	
	M	***SD***	***M***	***SD***	***t***	***p***
INDIRECT SELF-DESTRUCTIVENESS	125.625	25.093	123.348	20.394	3.451	0.005
A1 – Transgression and Risk	39.313	11.047	36.978	11.632	2.663	0.005
A2 – Poor Health Maintenance	26.812	6.229	23.913	4.727	2.749	0.008
A3 – Personal and Social Neglects	31.063	8.511	30.174	6.891	2.254	0.05
A4 – Lack of Planfulness	19.031	4.728	22.696	5.593	−3.727	0.0003
A5 – Helplessness, Passiveness	9.438	2.917	12.913	1.895	−5.140	0.000001

Tab. 3. Comparisons of CS-DS scores in women and men with schizophrenia

scores on most indices/(sub)scales: Indirect Self-Destructiveness (global index), A1 (Transgression and Risk), A2 (Poor Health Maintenance) and A3 (Personal and Social Neglects), while they achieved lower scores on A4 (Lack of Planfulness) and A5 (Helplessness, Passiveness).

DISCUSSION

Results of research to date indicate that the psychotic process (schizophrenia) increases indirectly self-destructive tendencies in patients with schizophrenia (Tsirigotis, 2018). Schizophrenic disorders are a predictor explaining the indirect self-destructiveness syndrome in the said patients. An important factor in determining indirect self-destructiveness among schizophrenic and paranoid disorders and symptoms appeared to be persecutory ideas, in particular the sense of injustice and experiencing one's life as an immense effort (Tsirigotis et al., 2016).

Women with schizophrenia and healthy controls

The study results indicate that women with schizophrenia achieved higher scores than healthy ones on almost all indices and (sub)scales of indirect self-destructiveness. It is possible that the psychotic process makes indirect self-destructiveness as a generalised behavioural tendency occur in them with a greater intensity.

Women with schizophrenia more often than healthy ones exhibited behaviours crossing or breaking from certain

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boundaries* or norms (A1 – Transgression); as a matter of fact, even schizophrenia itself may be considered a kind of blurring of the boundary between the norm and pathology, the real world and the world of psychotic experiences and/or health and (mental) disease.

Similarly, they showed more personal and social neglects than healthy women (A3 – Personal and Social Neglects); most probably, the disease process and its effects make the women not always able to take care of their own affairs.

Schizophrenic women also presented more deficiencies in planning their actions than healthy ones (A4 – Lack of Planfulness). It is possible that the burden of and struggle with the disease and its negative consequences consume so much of their psychological resources that they are incapable of planning and integrating their actions to a comparable extent as healthy women.

A natural consequence of the said deficits arising from indirect self-destructiveness and its categories was a stronger sense of helplessness than in healthy women (A5 – Helplessness).

The only category of indirect self-destructiveness which was less intense in women with schizophrenia than in healthy controls was poor health maintenance (A2 – Poor Health Maintenance). The awareness of mental disease seems to make them neglect their health less than the healthy ones, even though attending to their own health requires more involvement from them.

Women and men with schizophrenia

The study results indicate that the intensity of indirect self-destructiveness as a generalised behavioural tendency (or syndrome) was higher in women with schizophrenia than in men with the disease. Therefore, women may be presumed to more often and/or intensely exhibit tendencies and behaviours that, despite being initially convenient or pleasant, may prove (physically or psychologically) harmful in the long run.

The results differ from those observed in the healthy population (Suchańska, 1998; Tsirigotis et al., 2013), where it was men who displayed a higher intensity of both indirect self-destructiveness and most of its categories. Thus, it can be supposed that the schizophrenic process also causes such changes in women's psycho(patho)logical functioning.

They exhibited stronger tendencies towards taking actions that cross certain boundaries or barriers (A1 – Transgression). Transgressive behaviours are a major component of the active form of indirect self-destructiveness. It can be assumed that, in those women, it is transgression in the sense of crossing boundaries (cf. the etymology of the term "transgression" above) and norms that are socially and culturally established for their biological sex. As a matter of fact, according to the transgressive concept of the human, humans by their very nature exhibit a tendency towards transgression, i.e. crossing boundaries and going beyond what has been achieved so far (Kozielecki, 1987, 1997); an even earlier study, having a similar overtone and concerning cognitive psychology processes, emphasised going beyond information given (Bruner, 1973).

In the contemporary world, women increasingly often cross the boundary between matters traditionally considered feminine and those considered masculine in both family and social life: they more and more commonly perform actions or do jobs traditionally regarded as masculine and many a time earn more than men; the phenomenon may apply to individuals with schizophrenia, too. It may be exactly that aspect of transgression in their case.

As mentioned above, an indirectly self-destructive tendency includes not only taking dangerous actions (active form), but also omitting or neglecting those which could improve the quality of one's life (passive form). Women with schizophrenia neglected their health more commonly than men (A2 – Poor Health Maintenance). It is an interesting result, as another study observed better treatment adherence among women and even more over-adaptation and conformity (Riecher-Rössler et al., 2018). It may, however, be only their subjective feeling of being guilty of such neglect. There is a commonly held belief that women more often use (or should use) healthcare services by getting, for example, regular gynaecological check-ups. Having to attend to both their physical health (as women) and mental health (as schizophrenia sufferers), they can easily miss or neglect something or – at least – have such a feeling (compared to men suffering from schizophrenia who neglected their health to a lesser extent).

In the scope of their personal and social matters (A3 – Personal and Social Neglects), women also displayed more neglects than men suffering from schizophrenia. That means that those women more often experience personal and social failures due to abandoning actions that might improve their personal and social situation or interpersonal relations. However, it should be kept in mind that proportionally far more women than men in the study group were married, and in the traditional (mainly patriarchal) family model it is mostly women (wives, mothers) who are responsible for managing the household. It is also known that the more duties one has, the easier it is to miss or neglect something, or at least have such a feeling.

More or less for that reason, Lack of Planfulness (A4) occurred to a lesser extent in women with schizophrenia than in men with the disease. Lack of planfulness is often associated with a tendency to forget about or ignore matters important at a certain point in one's life, and to be careless in everyday living. It was observed that not only female sex, but also the psychological dimension of femininity were a protective factor against such attitudes and behaviours (Tsirigotis et al., 2013). Moreover, carrying out professional

* Etymology – transgression: an act that goes beyond generally accepted boundaries. In classical Latin, "a going over, a going across," noun of action from *transgressus*, past participle of transgredi "step across, step over; climb over, pass, go beyond," from *trans-* "*across*" + *gradi* (past participle gressus) "to walk, go" (Barnhart, 1999; Harper, 2020; Webster's Universal College Dictionary, 1997).

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tasks and running a household, with a multitude of chores it entails, requires women (also with schizophrenia) to be able to plan their actions. Even contraception (e.g. hormonal) is most often the women's responsibility since a majority of such agents (except for condoms) are addressed at them, not to mention "natural" family planning, whereas it is not necessarily like that in men with schizophrenia and, if so, to a smaller extent.

Women displayed a lower level of helplessness in the face of problems and difficulties than men with schizophrenia (A5 – Helplessness). Many authors (cf. Seligman, 2006, 2007) claim that women experience more than enough situations of (learned) helplessness in their lives. Hence, it is possible that they are better "trained" in coping with difficult situations and thus handle them better than men, thereby overcoming the feeling of helplessness, because they have – simply – learnt how to do that. That claim can also be substantiated by the fact that women in the study group were not maintained by their families, and thus did not put an additional burden on them, while the men did. The said facts may suggest that women suffering from schizophrenia are better adjusted psychosocially. At this point, it is worth mentioning the results of another study which found that the feeling of helplessness and hopelessness in the face of difficult situations is stronger in men than in women; and that the feeling of helplessness is even connected with the psychological dimension of masculinity (Tsirigotis et al., 2013). It may be the reason why men with schizophrenia more often and to a greater extent (ab)used alcohol and other psychoactive substances, which is in line with the findings of other studies (Riecher-Rössler et al., 2018; Tsirigotis, 2018). Additionally, the indicators of higher stress sensitivity were found in men (Riecher-Rössler et al., 2018).

The above results are puzzling. Although indirect self-destructiveness as a generalised behavioural tendency and some of its categories (A1 – Transgression, A2 – Poor Health Maintenance, A3 – Personal and Social Neglects) were more intense in women than in men with schizophrenia, women showed more characteristics of relatively good psychosocial adjustment than men. Proportionally more women had higher education, were married, and reported receiving support, though none of them was actually maintained by their family, so *de facto* they did not receive financial or material support. The opposite situation occurred in men: even though proportionally considerably more men were maintained by their families, and hence *de facto* received financial or material support, slightly more than half of them stated that they did not receive support. The findings of another research project were similar: women had better social functioning, and were more often in employment or education and living with their own children (Riecher-Rössler et al., 2018). That sociodemographic characteristic seems not to be unconnected with less intense lack of planfulness and helplessness in those women. Those factors appear to be intertwined to a certain extent. Greater integration of one's intentions and behaviours, as well as a lower sense of helplessness, may result in a higher level of education. On the other hand, the presence of a partner in a relationship may result in a stronger sense of social support and a lower feeling of helplessness. It is fairly possible that the factors interact with each other in a mutually enhancing way. It may also be the case that being in a relationship and the resulting sense of support reduce the feeling of helplessness and contribute to more effective planning of one's actions, among others, in the form of acquiring higher education. Moreover, other projects have shown links between schizophrenia and its symptoms and the menstrual cycle (Ray et al., 2020); there is increasing evidence for oestrogens to have a psychoprotective effect in women (Riecher-Rössler et al., 2018).

The obtained findings may contribute to providing women with schizophrenia with more effective pharmacological and psychosocial help. The differences observed in the categories of indirect self-destructiveness could provide insights into how women with schizophrenia manage their disease and how their illness leads to problems related to those behaviours, as well as practical guidelines for helping women with their disease and indirect self-destructiveness.

Comprehensive therapeutic, i.e. psychiatric, psychological and social interventions should serve to enhance the "self" defence and self-care functions, and improve the women's self-image and evaluation of adequacy and efficiency. Working with those patients towards increasing their life satisfaction, despite the fact that life did not spare them suffering, seems to be equally important in (psycho)therapy. The mobilisation and orientation of their actions towards those in favour of their development and health appear as crucial aspects.

The need for services to be sensitive to the diversity of women's needs and backgrounds including race, sexuality, and disability (Chandra et al., 2019), and better tailored treatments and improved outcomes for women (Riecher-Rössler et al., 2018) are of vital importance.

The reappraisal of women's mental health presentations in the context of their complex and often traumatic lives (Chandra et al., 2019) merits continuation and development, the more so that women's attempts to seek help are often negatively questioned by family members and service providers (Riecher-Rössler et al., 2018).

Integrating gender in all aspects of quality improvement is necessary and the planning of mental health services or structures must also include "women-friendly" aspects (Chandra et al., 2019). Gender-sensitive mental health services are essential, in particular for women with schizophrenia or other disorders/problems (Chandra et al., 2019), including indirect self-destructiveness as a generalised behavioural tendency and its categories.

CONCLUSIONS

The fact that more intense indirect self-destructiveness as a generalised behavioural tendency and its categories is seen in women than in men with schizophrenia is a particularly

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important phenomenon, taking into account the fact that women have been reported to have a more favourable course and better psychosocial "outcome" of the disease, better social functioning with more common recovery, better compliance, treatment response and illness insight, and less substance (ab)use than men (Riecher-Rössler et al., 2018). It is an observation that merits more extensive and in-depth exploration.

Certainly, this paper has not exhausted all aspects of indirect self-destructiveness in women with schizophrenia, so further research is necessary. The study has some limitations, one of which may be the impact of antipsychotic medications, and especially their side effects, on the psychological functioning of women with schizophrenia. That impact, however, cannot be avoided as, in most cases, women with schizophrenia have to be on medication throughout their lives.

Conflict of interest

The author does not declare any financial or personal links to other persons or organisations that could adversely affect the content of this publication or claim rights thereto.

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