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Case Study

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Transition in session: A case study of adjustment disorder and the integration of culturally informed treatment in postsocialist Slovenia

Abstract

This article contextualizes adjustment disorder as an intelligible cultural response to structural violence and moral breakdown in postsocialist transition rather than an individual pathology. It draws on ethnographic field work and a detailed case study of Petra, a Slovenian woman who lost stable employment during economic restructuring and subsequently developed paralysis which led to her adjustment disorder diagnosis. Through the analysis of the discrepancies between psychiatric and "patient's" explanatory models, illness narratives, and healing practices this case demonstrates that adjustment disorder represents a moral and relational rupture within a transformed social reality where the severing of social solidarity and reciprocal belonging shows correlation in contributing to both psychological distress and physical symptomatology. The article proposes utilization of the concept of social defeat as an analytical framework for the mental health practitioners, allowing them to explore, understand, and incorporate social, cultural, and historical contexts in which adjustment disorder is embedded in the postsocialist region. The study demonstrates how standardized mental health treatment alone proved insufficient without restoration of social participation and community reintegration, highlighting the necessity of culturally informed treatment/therapeutic approaches. Culturally informed treatment guidelines are proposed that are centered on the collective part of the self, utilizing language-based interventions grounded in Slovenian grammatical structures to encode therapeutic relationships and healing.

Keywords: adjustment disorder, mental health, postsocialism, social defeat, structural violence, Slovenia

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Introduction

Adjustment Disorder (AjD) represents one of the most widespread[1–3] yet understudied mental health conditions occupying a critical space between normative stress responses and more severe psychiatric disorders.[1,4] According to ICD-11 and DSM-5, AjD is considered a maladaptive reaction characterized by an individual's disproportionate emotional and psychological response to significant life stressors or prolonged stress exposure.[1,5] The condition typically emerges within one month of a triggering event, such as illness, family conflict, disability, financial difficulties, job loss, or other severe psychosocial stressors, and manifests through two primary features: preoccupation with the stressor or its consequences and failure to adapt.[5–7] Preoccupation involves persistent, distressing thoughts, worry, or rumination about the stressor, while failure to adapt refers to generalized stress responses such as sleep disturbances or concentration difficulties that substantially impair functioning in social, occupational, educational, or other important areas of one's life.[1,5]

While AjD can serve as a valuable diagnostic category, its usability has remained variable due to concerns about clinical validity and reliability,[1,8–11] blurred boundaries with other conditions,[8,9,12] as well as limited diagnosis-specific treatment options.[1,8,13] This ongoing tension between clinical utility and diagnostic validity persists as a central theme in contemporary AjD research.[13] Yet, AjD remains one of the most frequently used psychiatric diagnoses globally and has often become a bureaucratic placeholder for what does not clearly fit in other diagnostic categories.[8,12] The condition thus demonstrates remarkable variation in prevalence, such as among cancer[14] and cardiac patients,[15] children,[13,16] refugees,[17] or in the reactions to Covid-19 pandemic.[12]

Anthropological framework for understanding AjD

Psychiatric definitions assume that stressors are discrete events and that pathology lies within the individual psychological vulnerability, where one's coping mechanisms prove inadequate to manage the intensity or duration of the reaction to the event. Ethnographic findings complicate this framing. A growing body of scholarship in transcultural psychiatry and anthropology reveals fundamental limitations of universalizing approaches when applied to individuals from different cultural contexts.[18–23] The notion of universality becomes particularly problematic in discussions of mental health because what is regarded as illness varies significantly across different cultures.

Conceptualizations of health and illness are fundamentally shaped by cultural frameworks as they are intrinsically tied to cultural perceptions and definitions of what constitutes normal versus pathological functioning and behavior within the specific cultural, social, economic, and political contexts.[18–23] These standards of normality are further intimately connected to broader cultural notions of personhood and it is precisely at these intersections that mental illness is negotiated.[24] I use the analytical concept of personhood because it encompasses the constitution of identity through relations with others, local ideas of what it means to be a person and who is regarded as having a fully human status.[25–28] When Slovenians express the notion of personhood they frame it as a sense of being treated as a human being, which makes it an integral part of such experience.[8,29,30]

Anthropological findings demonstrate and emphasize that symptom expression, experience, presentation and meaning vary substantially across cultural contexts.[18,19,21,22] The same is true for illness and health behavior,[18,20,31,32] as well as decision-making about treatment seeking and compliance.[18,33,34] Yet, treatment approaches for AjD remain uniform, mostly consisting of psychotherapeutic, and pharmacological interventions[1,8] that have been developed in Western contexts and became globally applied interventions. This creates a critical gap when treating individuals from contexts fundamentally different from Western individualistic frameworks. The central problem is epistemological. Namely, psychiatric diagnostic categories and treatment protocols reflect Western culturally specific assumptions and notions of mental health, adaptation, agency, self, and personhood that diverge substantially from non-Western conceptions of psychological distress.[35,36]

Diagnosing AjD, therefore, requires careful attention to multiple contextual factors that shape both the stressor and the individual's response to it. The timing, intensity, and nature of the stressful event must be considered alongside the person's current life circumstances, the persistence and severity of resulting symptoms, and cultural norms regarding emotional expression.[37] Additionally, the contextual sensitivity is essential because the experience, manifestation, and interpretation of the condition is deeply rooted in and shaped by local historical, social, and cultural contexts, interpersonal relationships in which people are embedded, and what for them means to be a person and a social agent within these contexts.

The gap between universal psychiatric frameworks and culturally specific distress becomes particularly acute in postsocialist contexts, where recent social, economic, and political transformations have fundamentally reorganized social structures, severely disrupting people's everyday lives by introducing new ways of living, challenging local cultural norms, standards of normality and morality, and disrupting the ways people think about themselves. Across Eastern Europe, anthropologists have documented profound social consequences of postsocialist transformations, including high increase in unemployment, poverty, fragmentation of social ties, addiction, mental health disorders, and institutional distrust.[8,38–46]

Since Slovenia's transition from socialism (under Yugoslavia) to capitalism (under an independent country) in the 1990s, Slovenian psychiatrists[8] and statistical data[47–49] report on the sharp rise of mental health diagnoses, among which AjD has shown the most consistent growth in its rates. This extraordinary rise cannot be understood as a simple increase in individual pathology, but rather as a psychiatric encoding of broader social and economic transformation.

Methodology

The study was conducted in one of the bigger cities in Slovenia, which became an independent country after the collapse of Yugoslavia in early 1990s. Presented case study and study results are based on an ethnographic fieldwork conducted over a 30-month period in 2016, 2020, 2021, and 2022 utilizing multiple qualitative methods. During my time at the Brunel University London, institutional ethical approval was obtained from College of Business, Arts and Social Sciences Research Ethics Committee (ref. number: 23888-MHR-Jul/2020-26422-2) prior to the fieldwork commencement, whereas the other part was conducted as a part of independent research. In both cases, the study was conducted in accordance with ethical guidelines for anthropological research as well as in abidance to local conventions. All identifying information was removed from the interview transcripts and field notes, and participants' names, specific workplace affiliations, geographical location, and other potentially identifying details were replaced with pseudonyms and generic descriptors to preserve anonymity and analytical integrity of the findings.

The fieldwork included the collection of 24 semi-structured interviews and informal conversations with mental health practitioners (Slovenian psychiatrists, clinical psychologists, and psychotherapists (participant group 1)), and 15 semi-structured interviews with Slovenians who were diagnosed and recovered from AjD within the last 10 years from the start of the fieldwork (participant group 2). Participant observation was conducted through Petra's journey with AjD. Informed consent was sought from all participants, including Petra's renewed consent prior to including her in this case study. Participant group 1 was invited to participate through personal contacts and email, whereas Slovenians diagnosed with AjD were recruited through snowball sampling within the local community. Inclusion criteria for participant group 2 included a previous diagnosis of AjD and being consenting adults over 18 years of age. No exclusion criteria based on gender, employment status, education level, or socioeconomic background were applied as the study deliberately sought to capture diverse experience across the population. Participant group 1 was gender mixed, whereas group 2 randomly consisted of all women participants between 45 and 60 years old.

Additionally, the proposed treatment guidelines were developed during my consultation work in 2021 and 2022 with Slovenians diagnosed, *inter alia*, with AjD. The analysis included thematic analysis of explanatory models and recurring illness narratives. This rich narrative material is essential for understanding AjD, as it illuminates nuanced dimensions of participants' experience that conventional psychiatric frameworks often fail to capture.[33,50] Attending to participants' accounts reveals how the condition emerges at the intersection of lived experience, institutional failure, cultural meanings, and historical context.

Case study

The state's abandonment and the demand for self-responsibilization

Petra, a highly educated married woman in her early 50s, represents a category of individuals profoundly affected by postsocialist restructuring. Prior to her illness, she had worked for decades in a managerial position within one of Slovenian companies in Maribor, until the company fell into private hands and restructuring led to mass employment terminations, including Petra's. After losing her employment, Petra was included in one of the public work programs by the state's Employment Services and a few precarious employment opportunities, none of which lasted more than a year. She dutifully attended all the seminars organized by the Employment Services, where she was introduced to the logic that she had to "take her life into her own hands" and "create her own work position". The aftermath of failure to secure stable employment proved devastating, not simply due to financial strain, but mostly due to social erasure. The turning point came one day after 4 years of effort to create a stable employment, when she became paralyzed from both of her knees down. Not long after medical tests diagnosed her paralysis as peripheral neuropathy, the damage to the nerves outside the brain and spinal cord, causing pain, numbness, tingling, or muscle weakness in the hands or feet,[51] Petra received a psychiatric diagnosis of AjD as a result of her new physical condition. Her symptoms spanned from high sensitivity (cried and agitated easily), insomnia, feelings of meaninglessness and hopelessness, restlessness, paralysis (inability to walk) and lack of

willpower, headaches, loss of appetite and rapid weight loss. She was prescribed Lyrica for neuropathic pain and Cipralex (antidepressant) and Helex (anxiolytic) for AjD.

What follows is a part of my conversations with Petra that exemplifies a common pattern of participants' illness narratives. When I asked Petra what she thinks led to her illness, she expressed feeling too much stress and responsibility being placed on her. Her response laid bare the psychological architecture of her collapse.

"The most stressful was at the end when you ended up on the street again [Slovenian expression for losing an employment]. You are pretty much nobody. Besides the fact that you worked hard and endured a lot of stress in the process to get yourself to a certain position. So many exams, so much stress, so much work, so much effort, so many sacrifices, and in the end, you are over 50 years old, and you cannot even give this to anyone. If I could at least give it to someone! Everything that you created. It goes into nothing. It disappears. If only I could give my 55 exams to someone. If only I could give my work experience to someone. It seems that it would make things a lot easier. But no, go and rot with all of this somewhere! [she said this with visible disgust and anger]."

Petra's distress was not primarily about financial constraints. Rather, it centered on a profound rupture in her sense of social utility and reciprocal belonging. A lifetime of accumulated knowledge, credentials, and experience - the scaffolding of her personal and professional identity - had become utterly worthless not only in the labor market but also in the state's acknowledgement of her as a human being. More painfully, she possessed no means of transferring this value to others, no mechanism through which her sacrifice could be converted into social contribution. What at first glance appears as a representation of her experience of unemployment is a culturally and personally pathological severing of specific social ties through which Slovenian personhood is constituted and sustained.

Petra angrily described the effect the responsibility for finding an employment was placed on her had on her:

"You are pretty much nobody. After all these years of hard work in one of its companies [a state-owned company] the state says to you, 'Create your own workplace if you want to work'. /…/ From the state's side, NO ONE [emphasized in an angry voice] should ever utter to the people who gave so much that they should create their own workplace! They [the state] did not have that right! *Pokvarjeno* [Slovenian term denoting the ultimate moral violation]!"

The core violation emerges in abdication of the state's responsibilities after having promised security in exchange for decades of sacrifice and loyalty, placing that burden on individuals structurally incapable of bearing it alone. When I suggested this must feel unfair, Petra's response moved beyond individual grievance to indict the state's fundamental betrayal of its citizens. Upon asking if there is also an aspect of safety involved here, Petra responded with striking clarity.

"Absolutely! This is the same as if you said to a baby or to a little child, 'Cook yourself something if you want to eat' or to a handicapped person without legs, 'Walk! Well, if you want to walk. If you don't want to, then don't.' This is horrible!"

After working hard her whole life and fulfilling her social obligations to society and the state, after exhausting all the resources she had to secure an employment, instead of spending her old age in deserved retirement, Petra reported feeling abandoned and helpless with no provided ways in which she could live a socially decent life as a functional and contributing member of her wider community.

Divergent explanatory models

The study revealed fundamental discrepancies between the psychiatric understanding of the condition and the participants' own conceptions. Specifically, they differed in how they understood the root causes of the participants' distress. Psychiatrists attributed the condition to an excessive emotional response to the stressors that triggered the development of the disorder, wherein they listed distinct losses as such stressors: the loss of employment, a loved one, or health. Although the participants acknowledged and partially agreed with the psychiatrists' views that they were emotionally reactive to these stressors, they ultimately attributed their condition more directly to the stressors themselves, locating them in structural injustice, disrupted social relations, and encounters with the state and bureaucratic institutions. For the participants in this study, these stressors specifically centered around inhumane ways in which they were let go by their employers (various exploitation and intimidation tactics, sexual and psychological harassment, etc.) and their relationship/encounter with the state in the context of long-term unemployment. More specifically, across interviews, AjD was consistently associated with loss: not material but relational. Loss of social solidarity, reciprocity, human recognition, dignity, and personhood were commonly expressed as the most painful losses and moral violations leading to feelings of helplessness, injustice, profound depersonalization and dehumanization, and abandonment. Participants' narratives reveal that the feeling of mutually practiced social solidarity, reciprocity, and sociality that constitutes the collective part of the self is existentially and morally loaded and hence crucial for maintaining psychological stability among Slovenians.[29,30]

Treatment and healing

Discrepancies between the two models were even bigger in regard to treatment. When I asked Petra what helped her the most to get herself back on her feet, she did not mention the medication at all.

"Every day I make sure to think of something so that I have to go to town, just to get out, to get among people, to chat a little in a shop, or I go to the library without any particular goal, but I go there to talk a bit, to meet people, to speak a kind word to them and to get a kind word back. /…/ Sometimes you just go on a bus and you'll find a person to speak a few words with. Wherever there are people to talk to … I often talk to some strangers at the bus stop or in the shop. And that helps you, you know."

Upon asking why these seeming everyday interactions with strangers helped her, Petra paused for a few seconds and replied: "This gives me a lot. After all, you feel more alive. You feel like a somebody, a human being. Otherwise, it's like you died."

Such self-reintegration was possible after Petra regained her ability to walk, which came a few days after a consultation with an anthropologist who explained to her the social function of illness, namely that it abdicates one from the burdens of social and personal responsibilities once they become too heavy in a socially legitimate way. Exhausting her social and cultural repertoire of instructions to find possibilities to work, to be acknowledged as a human being, a useful member of the community, and taken care of by the state, Petra got symbolically (and physically) stuck in one place which was reflected in her nine-month long paralysis, finally being in a position to unload her responsibilities and be taken care of. Petra pinpointed

this as an important "positive influence" that she needed at the time "so that you stop perceiving yourself as a victim" of her circumstance.

Once she regained her ability to walk, Petra managed to establish a small social business for elderly care, beginning to work as a companion to the elderly which embedded her in daily practices that affirmed culturally proper relational dynamics. Petra stopped taking antidepressant and anxiolytic shortly after as her AjD symptoms subsided completely, whereas some tingling and pain in her legs have persisted to this day.

As psychiatrists treated the condition by alleviating symptoms with antidepressants and anxiolytics, Petra and other participants reported experiencing the healing effect in practices that helped them regain a sense of social solidarity and sociality by reintegration into the local community as contributing and useful members. By volunteering at the day center for children with learning disabilities or at a retirement home, starting a social business for elderly care, going to the store six times a day or taking a bus with no particular destination just to go among the people and socialize, participants reportedly restored feelings of own contribution and being treated like a human being in return. By being able to live out their collective part of the self in a culturally and morally proper way, participants seemed to restored their psychological stability and everyday functionality.

Discussion

This case study demonstrates that AjD in Slovenia cannot be separated from the historical and cultural context of postsocialist transformation. Understanding Petra's condition requires attending to the narrative account of herself and her deeply held cultural meanings, including moral frameworks and notions of personhood, while simultaneously situating that account within the historical and social structures that made her suffering intelligible and perhaps even inevitable.

Sociocultural and historical context

Understanding this case requires attention to Slovenian sociocultural configurations historically rooted in collectivism rather than individualism. Under a thousand years of feudalism and 20th century socialism organized around self-management principles, Slovenian identity and personhood were inherently tied to membership in social units that ensured each member's survival.[46,52] Domestic homesteads (in feudalism), socialist factories, and local communities (in self-management socialism) being such units constituted one's identity and personhood through collective participation,[46,53] wherein survival was throughout centuries understood as a collective endeavor.[46] In such an environment, a part of personhood is highly relational and embedded in group sacrifice and solidarity, wherein morality is established and highly judged on three focal points, one of which is located in strict reciprocal action towards all members regardless of their position.[29,30]

For Slovenians, the state occupied a morally charged position as responsible for ensuring citizens' security and survival as a matter of their right as human beings, whereas it was, on the other hand, met with severe distrust when it did not take care of people's survival.[46] The social contract involved exchanging self-sacrifice and labor for security and dignified social membership.[46,53] Such moral landscapes do not represent just cultural values but existential necessities, wherein being a person in Slovenia means being embedded in a web of social moral relations that affirm one's humanity.[29]

Social change has significantly reorganized such social dynamics, resulting in severe disruptions in people's everyday lives.[8] Postsocialist transition introduced capitalism with profound structural discontinuity with local culture[46] producing structural violence through privatization, intimidation strategies, exploitation, precarity, and forced resignations.[8] Simultaneously, neoliberal ideology introduced discourse of market-oriented rationality demanding proactive, self-responsible, flexible individuals.[39,54-56] One's survival, health, and employment now appeared as results of individual choice and effort, with employment responsibility shifted from the state to the individual.[54-56]

Today, Slovenians feel very strongly and intimately that the state is responsible for providing them the means for survival and is perceived completely immoral when it does not do so, while simultaneously, this same state does not function well in providing the people the ways to take care of their own survival.[53] Instead, Slovenians are often faced with manifold bureaucratic obstacles and difficulties that in an attempt to eradicate "socialistic mentality and practices" make it almost impossible for people to take the matter into their own hands in a legal and legitimate way.[8,46,53] Critically, this new system criminalizes, delegitimizes, and rejects collective action and social membership as "socialist mentality," the very frameworks that have historically and culturally organized Slovenian identity, personhood, morality, and survival. Therefore, today, one's encounter with the state seems not only characterized by certain distrust, but it also seems psychologically disabling.

Social defeat as an analytical framework for postsocialism

Petra is one of many Slovenian today, who experience the relationship/encounter with the state at a time of job loss and long-term unemployment through a cultural prism that generates an experience of social defeat, evoking the feelings of helplessness, injustice, dehumanization, and abandonment.[8] I propose utilizing the concept of social defeat as an analytical framework for mental health practitioners when exploring social, cultural, and historical contexts in which AjD is embedded in a postsocialist region.

In my proposition, I draw on the concept of social defeat as presented in Tanya Luhrmann's study where she shows the correlation between schizophrenia among the homeless in the United States and the sense of social defeat as being one of the social factors in their illness experience.[57] Luhrmann defined social defeat as an "experience of failure in social encounter, /…/ in which one person physically or symbolically loses to another one. The encounter /…/ must be contested (or /…/ [be] experience(d) /…/ as contested), and the individual must experience loss".[57] Although AjD in postsocialist Slovenia has a much different clinical and lived reality than schizophrenia in the United States certain conceptual elements of social defeat that accompany the illness experience transfer meaningfully across the two populations. While both populations experience a type of a relational rupture in certain social encounters accompanied by loss, humiliation, and disregard, the structural context and cultural meanings of such encounters, as well as the mechanisms through which social defeat becomes a lived reality, differ fundamentally.

A sense of social defeat linked to AjD in postsocialist Slovenia is characterized by the profound sense of helplessness, degradation, loss, humiliation, dehumanization, exclusion, and abandonment not only in specific contested interpersonal relationships within reorganized workplaces[29] but also in an all-encompassing relationship with the state.[8] While the system of lifetime employment and housing under socialism provided people with a sense of security in their everyday lives it is the liability of jobs combined with an absence

of cultural mechanisms to cope with such a situation that Slovenians face today[29,30] as own "survival (became) depended on skills people raised under communism didn't have".[45] Consequently, people have a chronic feeling of failure in their attempt to live up to expectations new conditions demand of them.[40]

For Slovenians experiencing social defeat in transition, social and structural isolation adopts a different form from homeless displacement. Namely, it emerges from severing the culturally proper social ties while the person remains physically present in their community. Petra did not become homeless, she became, in her own words, "nobody," which constitutes a different kind of social invisibility. For Slovenians, historically and culturally embedded in collectivist frameworks where personhood is constituted through group participation and reciprocal obligation, the loss of social belonging strikes at the existential core of selfhood. The experience of social defeat, then, operates through different moral landscapes shaped by specific local historical, social, economic, and cultural context, as well as through different cultural meanings that the sense of self and personhood are embedded in within a particular moral universe.

Despite the differences, the claim of this proposition is not the production of identical symptomatology across different contexts but rather the capacity of social defeat as an analytical framework to illuminate the mechanisms of how macro-level social processes can become inscribed in micro-level psychological distress and individual bodily experience. It cannot, however, fully account for why that distress takes the particular cultural forms that it does in each context. This framework is, therefore, better understood as providing a conceptual bridge that allows mental health practitioners to recognize the cultural, relational, and institutional dimensions of suffering that biomedical approaches typically exclude. However, applying it requires careful ethnographic and contextual work to understand how social defeat manifests specifically within Slovenian moral and cultural frameworks. Here, social defeat can function as an analytical lens that clarifies why standardized mental health treatment alone was insufficient and why healing required restoration of social participation and community recognition rather than symptom management alone.

Paralysis as embodied resistance

The emergence of Petra's paralysis following four years of exhausting and futile effort to secure stable employment reveals an underlying dynamic: when individual agency proves structurally impossible, the body speaks what consciousness cannot fully articulate. Petra's paralysis functioned as embodied resistance to an unjust social order that demanded from her to bear sole responsibility for creating surviving conditions dismantled by the state. The impossibility and absurdity of such demand is powerfully captured by the drawn parallels to demanding from someone without legs to walk. Petra's paralysis demonstrates how AjD in postsocialist Slovenia operates at the intersection of individual distress and collective structural violence. As such, it is not merely a psychological maladaptation to stressors, but a physiological inscription of the moral violations embedded in the postsocialist transition itself. Petra's testimony sheds light onto the severity of human cost of and vulnerability amid postsocialist transitions, creating conditions where somatic and psychological collapse becomes the only remaining language of protest.

AjD as a cultural response

Petra's illness trajectory challenges Western mental health assumptions that pathology resides in individual cognition, personal history, or emotional dysregulation. Instead, it demonstrates that for Slovenians embedded in collectivist frameworks, embodied resistance through illness becomes a culturally intelligible response when all sanctioned avenues for dignified social participation have been foreclosed. This is not a rejection of psychiatric diagnosis but rather a contextualization of it. Petra was validly diagnosed with AjD (she met ICD-11 criteria), but this diagnosis means something fundamentally different when understood through her own explanatory model and lived experience. What was essentially diagnosed and medicalized was not individual pathology but a cultural response to distress upon a "moral breakdown"[58] in particular pathological social conditions.

The somatic shift that correlated with the anthropologist's explanation of illness's social function reveals the therapeutic gap at the heart of biomedical approaches. Understanding her illness's social meaning, which resonated with Petra's own experience of the illness, seems to create a "symbolic closure"[59] – a part of the healing process that emerges when the healing ritual symbolically aligns with the "patient's" intuitive recognition of embodied cultural meanings.[59] Petra's regained mobility and subsequently established culturally meaningful work illustrates that restoration of social participation and relational personhood can present an important factor in her recovery.

Treatment guidelines proposition for a culturally informed approach to AjD in Slovenia

Developing particular tools that organize and structure treatment in a culturally meaningful way that addresses collective part of the self could become a useful complementary treatment/therapeutic tool as it has proven successful in my consultation sessions with Slovenians diagnosed, *inter alia*, with AjD, leading to symptom alleviation and restoring everyday functionality.

These guidelines recognize language not merely as a medium through which treatment/therapy occurs but itself as a therapeutic intervention. Language plays a crucial role in this endeavor as it provides us with a symbolic resource with which we come into being and which represents the world around us.[60-64] Our language not only shapes how we express ourselves, but also how we conceptualize reality, construct identity, and experience psychological distress.[63,65-68] Contemporary research in narrative medicine and linguistic anthropology demonstrates that the way individuals use language to describe their experience provides crucial diagnostic and therapeutic information.[65,68-71] Illness narratives - the stories people tell about their suffering - are not merely descriptive and explanatory but constitutive of illness itself, reflecting broader cultural patterns and impacting health behaviors and outcomes.[50,70,71] They reveal how individuals understand causation, locate agency, conceptualize recovery, and position themselves in relation to broader social worlds.[68,71] Rather than taking diagnostic categories as a baseline, this approach begins with engagement with the "patient's" own illness narrative, to gain an insight into the understanding of their suffering, where they locate causation, and what recovery means to them.

Centering collective part of the self and rethinking agency

In Slovenia, instead of being a pathological merger of identity boundaries, the collective part of the self is rather a culturally normative, proper, and healthy organization of personhood. Healing in such contexts, thus, requires not the dissolution of the collective part of the self and identity in favor of the individualist part, but its restoration and reintegration. Therapy that undercuts collective identity frameworks as many approaches in psychiatry, psychology,

and various forms of psychotherapy do, can be fundamentally misaligned with cultural meanings and local experience of mental health.

I propose a culturally informed complement to the AjD treatment in Slovenia with a fundamental recognition of the significance of the collective part of the self for psychological stability. When psychological stability is structured around collective belonging and particular ways in which relationships are properly organized in a certain culture, individual-focused therapy may miss the focal point of the "patient's" cosmological and, therefore, psychological orientation. Rather than locating distress in individual thoughts or emotions, these guidelines address the rupture in the collective, the severance of culturally proper relationship dynamic, and the state's refusal to recognize "patients" as participating members of the community.

Proposed treatment guidelines

The proposed treatment/therapeutic guidelines incorporate several key strategies that validate and address the collective part of the self as healthy rather than pathological organization of identity. Approach that addresses relational rupture by certain linguistic strategies and encouraging practices that resume living out this part of the self can be an important complement to the standardized interventions.

a) Strategy #1

One thing the participants expressed they wished to receive from the mental health practitioners is the acknowledgement and validation of the expressed moral violation before helping them illuminate the individual aspect that might have played a part in their condition. I talk more in detail about such violations within Slovenian moral landscapes elsewhere.[29]

b) Strategy #2

A critical element of treatment/therapy involves guiding "patients" in affirming the culturally aligned notion of agency. The latter is not found in individual responsibility for systemic problems, but in primary cultural instructions in how they respond to those problems by restoring their own sense of personhood. By helping the "patient" to find and develop social engagement and relationships in their everyday life that follow culturally proper and moral dynamics, forms an essential component of treatment/therapy where treatment goals center around restoration of social aspects of existence rather than individual ones. This, as a result, supports the restoration of reciprocal relationships, own social contribution, and community connection.

c) Strategy #3

Linguistic patterns often labeled as pathological by psychiatry, psychology, and psychotherapy may reflect culturally normative and even therapeutically useful patterns in Slovenian language and culture. Oftentimes, when Slovenians talk about their own experiences or feelings, they use impersonal second or third person forms. Instead of saying, for example, "this makes me angry", they would say "this makes you angry" or "this would make a person angry". In psychotherapy, for example, such linguistic patterns would be identified as "alienation/disconnection from oneself" and the "patient" would be encouraged or guided to switch to first-person narrative styles: "I feel angry". Such cases can reveal a critical cultural misunderstanding and discrepancy as the use of impersonal forms can be a reflection of deep linguistic and cultural configurations. In such cases, the emphasis on the first-person singular narrative can create internal conflict rather than alleviating it.

d) Strategy #4

Slovenian language possesses elaborate plurality forms distinct from English: singular, dual, and two plural forms. The dual form specifically refers to two people or things, occupying a grammatical space between the singular (isolated) and plural. This grammatical feature has profound implications for how relationships are linguistically expressed and experienced in life as well as in the treatment/therapeutic space. When the dual form is deployed by the mental health practitioner during the treatment/therapeutic process when referring to and talking about the "patient" and the therapeutic relationship, it creates a linguistic encoding of the dyadic relationship as a distinct social unit. Transference seems to be easily established through addressing the patient by "*sva*" ("the two of us are"), "*bova*" ("the two of us will"), "*Kaj naju najbolj boli?*" ("What hurts the two of us the most?") and so on.

The therapeutic outcomes of such linguistic intervention have been significant and consistent. Some "patients" notice it explicitly by mentioning that it made them feel safe, supported, and they perceive the interaction as warm, personal, and something that makes them form trust. Others, while unable to pinpoint precisely what creates the difference in the therapeutic/treatment encounter, similarly report feeling "heard" and "safe" with this linguistic approach. From a theoretical perspective, the dual form linguistically encodes the therapist-patient dyad as a meaningful relational unit, directly contradicting the "patient's" experience of social isolation and non-recognition. By being consistently referred to in the dual form, "patients" are linguistically positioned as part of a recognized social relationship - precisely what their AjD involves losing.

This culturally informed approach represents a significant modification of standardized mental health intervention protocols, offering enhanced effectiveness for individuals whose psychological distress is fundamentally rooted in relational and collective dimensions. By validating rather than correcting the "patient's" culturally "natural" linguistic patterns, therapists can strengthen the therapeutic alliance and allow language itself to become a medium for relational healing.

Conclusion

Anthropology is fundamentally concerned with understanding how individuals construct meaning of their suffering in ways that transcend the limitations of diagnostic categories and symptom checklists. Mental disorders are, therefore, not viewed as objective pre-existing entities waiting to be discovered and classified, but as socially constructed formations that emerge from the complex interaction between broader social structures and individual lived experiences. Consequently, psychological distress cannot be understood as merely the product of biological mechanisms in isolation. Rather, the experience of distress is always embedded within and shaped by specific cultural contexts and frameworks of meaning and is always mediated through the particular cultural configurations and understandings available within a person's community.

Through this framework, the case study of Petra illuminates AjD not as individual malfunction but as a comprehensible and possibly even inevitable response to institutional betrayal and social erasure, a rupture in a relational being. Hence, the rise of AjD in Slovenia signals the embodied consequences of transition in postsocialism. Understanding AjD requires moving beyond psychiatric and even psychotherapeutic models and attending to the social and cultural worlds in which distress is produced, understood, expressed, and potentially alleviated.

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First, Petra's anger, her sense of injustice, her feelings of abandonment were grounded in concrete policies and discourses of a postsocialist state that dismantled culturally appropriate social contract while simultaneously blaming individuals for their inability to survive in its absence. Petra's repeated failures to secure employment were not individual failures but structural ones. Yet, the neoliberal framework transformed structural unemployment into personal obligation, further disabling her and creating a chronic sense of social defeat. Second, for Slovenians, among whom sociality and mutual obligation within specific "domestic social units"[46] appear to hold existential and moral significance, the severance of social bonds constitutes a fundamental attack on one's sense of personhood and a stable sense of self. Petra's AjD emerged precisely at this intersection where individual psychology meets the refusal of society to recognize one's humanity.

This case demonstrates the critical necessity of culturally informed, structurally aware approaches to mental health in postsocialist contexts. Without understanding the moral consciousness embedded in local cosmologies, standardized mental health approaches often medicalize what is fundamentally a moral breakdown of subjectivity, while psychotherapeutic approaches rooted in individualism assume different meanings about the self, agency, and responsibility which may further alienate "patients" from their culturally constituted selves. Even the Slovenian language itself encodes collectivity through grammatical structures that linguistically encode what it means to be a person in Slovenia and social relationships in ways absent from many other, especially Western, languages. Healing in this context requires not merely symptom alleviation but restoration of relational and moral dimensions of distress. Petra's journey illustrates that recovery becomes possible not when individuals are asked to adapt to unjust conditions, but when they are supported in restoring the social connections, reciprocal obligations, and collective recognition that constitute personhood within their cultural context. In this sense, rather than medication alone, healing required reconstitution of solidarity, spaces where individuals could exercise meaningful contribution and be recognized as fully human.

The task of culturally informed therapy is, then, not to pathologize Petra's response but to help her restore what was severed/ruptured: a restoration of her human status and fully participating member of her community. Future directions for mental health care in Slovenia and other postsocialist contexts should prioritize:

A. Recognition of social and cultural determinants as complementary, not secondary, factors in distress;

B. Engagement with "patient's" own explanatory models and cultural frameworks;

C. Attention to the ways language, history, and social structures shape both the production of distress and possibilities for healing;

D. understanding of how linguistic structures encode relationships, identity, and agency, and recognizing that what appears to be "pathological" linguistic patterns may actually be culturally normative and therapeutically useful;

E. Strategic employment of these structures in treatment/therapeutic encounter rather than attempting to simply adopt the ones of global interventions;

F. Development of treatment/therapy that strengthens rather than undermines collective part of identity and personhood by encouraging creation and embeddedness of what is culturally perceived as "proper" dynamic of social interactions in the "patient's" everyday life.

By being open to a holistic understanding of mental health and well-being, mental illness and psychiatric diagnosis become a diagnostic window into postsocialist moral rupture and structural violence. Therefore, what is diagnosed and (over)medicalized here may not be pathology but rather cultural expression of distress or a cultural/local response to pathological social situations. By proposing that the intertwining of personal and cultural reflects psychological dynamics as a manifestation of specific social structure on an individual psychological level, Marcel Mauss and Claude Lévi-Strauss implied that the symptoms on an individual/micro level are much revealing of what is happening on the social/macro level.[72] Then, such collective sense of social defeat testifies on AjD in postsocialist Slovenia as simultaneously being a radical manifestation of such pathology and a radical resistance against it.

Limitations

Although this study presented consistent results across the studied population, the demographic limitations of the said population are clearly acknowledged by the author as it consisted of a small population of women between 45 and 60 years old.

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Conflict of interest

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