

# THE NORDIC PSYCHIATRIST

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## Welcome to the 32<sup>nd</sup> Nordic Congress of Psychiatry in Reykjavik June 13-16<sup>th</sup> 2018.

The congress will be hosted by the Icelandic Psychiatric Association in collaboration with the Joint Committee of the **Nordic Psychiatric Associations**. We are proud to introduce Harpa, Reykjavik's new Concert Hall and Conference Centre. Harpa is located in the heart of Reykjavik, overlooking the bay and mount Esja. It is close to most of the congress hotels, art galleries, shopping areas and restaurants.

The programme will feature plenary lectures, clinical symposia and posters.

**Warm regards from the Organizing Committee**

[www.ncp2018.is](http://www.ncp2018.is)



## Dear colleague,

**It is now December** – a busy month to most of us. So many tasks need to be accomplished before the holidays. I think many of us have some mixed feelings about New Year, a holiday encompassing the celebration of what lies ahead as well as giving a good time to reflect on what has just passed.

How has 2017 been to you? How was it to those around you? To what extent did it express things that happened in your surroundings – your environment?

Working as a psychiatrist, you are familiar with the integration of biological, psychological, and social perspectives in understanding and treating your patients. Three interfaces of environment. However, as clinicians, we are also much affected by environmental factors all around us, sometimes substantially impacting on the course of our working life.

The impact of how environmental factors affect us as doctors is the theme of this issue. We have aimed to keep the focus broad, resulting in thought-provoking reading on various perspectives of psychiatric work in our Nordic and Baltic countries.

Next year will be rewarding from a very psychiatric point of view. The Nordic Psychiatric Associations will again arrange a big psychiatric conference – this time in June in Reykjavik. I know that preparations are already in full swing.



As always, you will in this issue also read about the latest articles published by our common scientific journal, The Nordic Journal of Psychiatry.

I wish you all happy reading – and of course, a Happy New Year 2018!

**Hans-Peter Mofors, Editor**

# One flew over the cuckoo's nest

Andres Lehtmetts

**The notorious movie** based on Ken Kesey's novel for decades has come to symbolize evil psychiatry. Like it or not, but many political decisions to control psychiatry – such as the ban of ECT in some parts of Switzerland as an example – have the roots in the same period. No wonder that the United Nations, Council of Europe, as well as several other international bodies that are responsible for human rights have set standards for psychiatry and exercise control over psychiatric hospitals. The UN High Commissioner of Human Rights recently empowered a special rapporteur to report on the situation in psychiatry, and the report has been submitted and published in June this year. The document is called “Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (A/HCR/35/21), and for the ones who have not yet read it – it can easily be downloaded from the UN documents database.

**The report has raised a few eyebrows** – to put it mildly – particularly due to the image of psychiatry and psychiatrists that emerges from the document. The European Psychiatric Association has already reacted and the president Silvana Galderisi has sent a letter of concern to the president of the United Nations Human Rights Council. Do we agree that the biomedical approach should only be seen as a source of neglect, abuse and coercion and the one reason for the current unsatisfactory status of mental health care? Or is it rather the still unmet need for parity of esteem between mental and physical health of citizens and the paucity of financial resources allocated to mental health care? The report promotes a negative image of specialised psychiatric care and lacks a constructive approach when identifying the weaknesses and unmet needs of mental services, and it undermines the therapeutic alliance between psychiatrists, users, and relatives.

**We should not exclude constructive criticism** of the shortcomings that every medical specialty faces. But modern psychiatry does not deserve to be called reductionist and a source for human rights violations, useless in its services. This is not a good start for the dialogue to look for new approaches and developments. We should



**Andres Lehtmetts**  
MD, Chairman, Nordic Psychiatric Associations

second to the president of the EPA in her call for a revision of this document. And we should remain calm, constructive and positive in our dialogue even with the most fierce critics of our profession. ■



# Designing the modern psychiatric hospital: Environment as therapy

Hannele Cederström  
Allan Seppänen

The hospital building stock in the Nordic countries is becoming out-dated. As a result, hospitals are struggling to meet modern technical requirements and standards of care. Accordingly, several architecture competitions have been held in recent years in the Nordic region, and a number of hospital construction projects have started up. A common trend in the designs for these projects is that psychiatric care – whether integrated into the main hospital facilities or accommodated in a separate building – is being brought closer to everyday life. Attempts are thus being made to overcome the powerful prejudices and isolation which psychiatric care has had to face. Developments in treatment and the re-structuring of care services offer new opportunities, to which care environments must be capable of responding.

## **Developments in psychiatric care and care environments**

Ideas about the causes and treatment of mental illnesses have varied over time. At the beginning of the 19th century, mental illness was still widely believed to be a punishment from God; thus, the mentally afflicted were taken care of by priests rather than doctors. Mental hospitals were little different from prisons – institutions where those who behaved deviantly were kept segregated from society. More humane treatments and facilities started to become widespread only at the beginning of the 20th century. The first effective psychiatric drugs became widely available in the 1950s, and, as a consequence, the mental hospital network started to change; by the 1980s and 90s, the trend away from institutionalisation towards out-patient care was clearly discernible.



Allan Seppänen, photo: Esa Luoto

Yet even today, looking at our old “forest hospitals”, surrounded by nature far from centres of habitation, it is easy to envisage psychiatric care as something isolated in both organizational and geographic terms. However, mental disorders are now increasingly understood as illnesses like any other, and psychiatric treatment facilities are often located in general hospitals, making them more easily accessible. Psychiatric disorders across the diagnostic spectrum can be treated more successfully than before and, as people become better informed and attitudes change, the threshold for seeking treatment has got lower. The focus is increasingly on out-patient treatment; hospital stays are kept as short as possible in order to prevent patients becoming institutionalised. In Finland, for example, the annual number of in-patients receiving specialised psychiatric





**Nature can be utilized in a therapeutic setting even in an urban environment. Picture: Hannele Cederström.**

care has gone down over the last ten years, although the total number of psychiatric patients has gone up over the same period. The hospital's role is thus seen to support and rehabilitate the patient towards increasing independence.

Developments in psychiatric care environments and societal attitudes towards mental health issues are closely intertwined. New ideas and objectives place new demands on the care environment. In the future, more emphasis will be placed on prevention and long-term management of disorders, in addition to treating the acute stages of a disease. Responsibility for maintaining good standards of health will be dispersed more widely throughout society, taking into consideration people's life situation as a whole, from living habits and domestic arrangements, to specific forms of treatment for particular health problems. Changing views on treatment must be matched by changes in operational models, which are themselves bound up with the design of hospital buildings. The hospital of the future will work according to process-based operational models, which will be developed simultaneously with spaces and facilities. New spatial layouts must facilitate the progress of seamless, patient-centred treatment processes and multi-professional teamwork.

### **Integration into the city**

As in-patient care is being organised in shorter and more frequent periods of treatment, hospitals must be easily accessible. New hospitals should therefore be located in urban centres, close to where people live and with good public transport connections. This also makes it easier for family members to participate in patients' care, and make commuting easier for staff.

A hospital's physical location also affects the associations it arouses in people's minds. When the hospital is incorporated into the life of the city, it loses some of its institutional image; public space can be (partly) extended into the hospital buildings, making them a natural part of the "territory" of the local people, rather than a no-go area. The interface between town and psychiatric hospital blurs as activities open to the public take place on hospital premises. Similarly, patients, too, come closer to everyday life instead of being alienated from it. In an urban location, the hospital can also take advantage of synergies in provision of services.

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### **Adaptability**

Hospital buildings must comply with current conceptions of a good care environment, while being flexible enough to accommodate changing needs in the future. Modular design, standardized spaces, functional zones and well-planned positioning of load-bearing structures and technical infrastructure are all ways of building in adaptability. The possibility to extend a building or units within it at a later date must also be taken into account at the planning stage. In modern hospitals, the various spaces are not, generally speaking, highly differentiated, or dedicated to particular functions or individual people; this enables optimal use of available space.

### **A care environment which aids recovery**

There are many ways in which the physical environment can improve patient experience and wellbeing, and support the recuperation process. Evidence-Based Design is founded on research into the link between characteristics of the care environment and recuperation and wellbeing. This is the essence of modern health-care architecture, although investigating the direct effects of different environmental factors is extremely challenging. Equally valuable feedback on the effects of architectural solutions is the practical experience of people who frequent the building. The views of staff members and patients should be taken into consideration throughout the planning process.

### **Nature and light**

The presence of nature has a stimulating effect on sensation, concentration, and other physiological functions. It also aids recovery from exhaustion and stress. Even in an urban environment, nature can be used as a way of regulating mood and sense of self. The presence of nature, in the form of a garden for instance, increases the sense of wellbeing and satisfaction with the care environment among patients, their families, and hospital staff alike. Including elements of nature in the care environment reduces treatment times and accelerates recuperation, thus providing economic benefits, too. Well-being can also be affected by interior design solutions, such as the use of natural light and choice of materials. For example, interior wooden surfaces have been shown to confer physiological and psychological health benefits; indeed, hospital designers in many countries have started to favour wood.

### **Solitude and social contact**

A hospital's physical environment should enable patients to choose whether to be alone or in company. Individuals need privacy, their own space away from

external stresses, where they can control their relations with others; the option of being alone can be strongly empowering. Yet, the freedom to choose between solitude and company has been observed to increase social contacts. The immediate surroundings of the building, too, can be utilised as a social environment. If the hospital grounds are pleasant and well tended, people will need no encouragement to use them, and opportunities for social activities will increase naturally.

### **The hospital experience**

Hospitals of the institutional style readily elicit negative associations of exclusion, isolation and control. Although a modern psychiatric hospital must certainly be efficient, secure and well managed, at the same time its architectural solutions should be people-centred, giving expression to care values based on universal respect.

In large hospitals, simply finding one's way can be a stressful experience for patients and visitors. The layout of the building can be thought of like a town; to help people get an overall picture of the whole place and orient themselves within it, the building can be divided into smaller "districts" that are easily distinguished from each other, with clear routes connecting them, and features that stand out, such as courtyards.

### **Digitalisation and innovation**

Utilizing today's information technology, patients can be contacted and medical records accessed remotely, so treatment is no longer tied to a particular room, or even a particular building. This enables a patient-centred approach to treatment, where the nurse and doctor can meet the patient outside the hospital premises, in a public space, or at the patient's home.

Although remote connectivity offers new treatment possibilities and environments to an ever-increasing extent, it cannot completely replace the specialised facilities of a hospital. The modern psychiatric hospital has increasingly important roles to play, as a stable and secure centre for treatment, knowledge and research, and as an environment for social interaction, rehabilitation and wellbeing. A psychiatric hospital in an urban setting, with some areas open to the public, also contributes towards creating more open-minded attitudes towards mental health disorders. ■

**Acknowledgments: Translated from the original Finnish manuscript by Ann Seppänen, B.A., M.Ed.**



# Resilience

Majda Panah

During the 10<sup>th</sup> semester of my medical education I finished a thesis — *a review on Transgenerational transmission of PTSD between parents and their offspring*. This is an important subject considering the high number of refugees who are at risk of developing PTSD, and their children being exposed to secondary traumatisation. The term secondary traumatisation has been used to describe the influence of a parent's PTSD and its effect on their offspring. The underlying premise is that the trauma-related symptoms can be passed to children.



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**I examined the term resilience.** One of the included studies measured resilience and vulnerability in refugee children of parents who have been exposed to trauma and developed PTSD, and parents who have not been exposed to trauma. The study found that children without posttraumatic stress symptoms but with traumatised parents scored more positively with respect to emotionality, family relations, peer relations and pro-social behaviour, compared with children in the same group with posttraumatic stress symptoms. I referred to the concept *salutogenic features*, and explained that children of traumatized parents who demonstrated no evidence of having developed PTSD symptoms, might have “*displayed salutogenic features (freedom from PTSD/PTSS) as a consequence of their resilience which was characterized by their maintaining adequate family and peer relations.*”

Aaron Antonovsky developed the theory of salutogenesis. This term highlights the aspects of well-being rather than pathogenesis. Antonovsky refers to Sense of Coherence (SOC) theory, which is based on three important conditions: a person's environment being *comprehensive* (the stimulations being predictable, structured and explainable), *manageable* (the person having resources to respond appropriately to the stimuli), and *meaningful* (it is worth engaging in the reac-

tions you give on stimuli). Thus, salutogenesis may play a protective role in the process of secondary traumatisation of children whose parents suffer from PTSD.

Another study (1) included in the review suggested a model (Figure 1), which demonstrates factors that need to be considered in obtaining a better understanding of secondary traumatisation of children whose parents suffer from PTSD. The model consists of the child as a central focus, and several factors such as genetic predisposition, the child's biological parents and their mental health, resources, and coping strategies, which may influence a child's mental health. The overall family context must be considered, such as the impact of siblings, family functioning such as patterns of communication, parenting capacity, and general world-views. Finally, the role of social environments needs to be taken into account, such as level of integration into a community, as well as amount of help and support offered by the community.

Apart from my interest for the current subject *secondary traumatisation* among refugees, my personal background also has a relevant influence in this context. My parents are refugees from Afghanistan, and they both experienced the consequences of war and their flight to Denmark. The reflections on how this affected my siblings and myself have been unavoidable

while working on the review. How did we process the secondary traumatisation of our parents?

My father does not suffer from PTSD, despite his political involvement and later persecution in Afghanistan during the war. My mother was diagnosed with PTSD a few years after our arrival to Denmark. In my family, two factors played a role in preventing secondary traumatisation, and strengthening resilience. First, factors inside my family, and second the social environments.

The general family relation has been an important factor for us during our upbringing in rough environments. Our family relation has been very close, strong and protective. For me personally and mentally, this has provided a huge security and stability during my upbringing. Additionally, despite many challenges my parents tried to provide a normal life for us by sending us to school, and they supported us in being active with hobbies and having friends during our stay/flight in different countries. This probably strengthened our SOC.

Based on these reflections, secondary traumatisation (and resilience) among children with parents suffering from PTSD, is complex in its development and

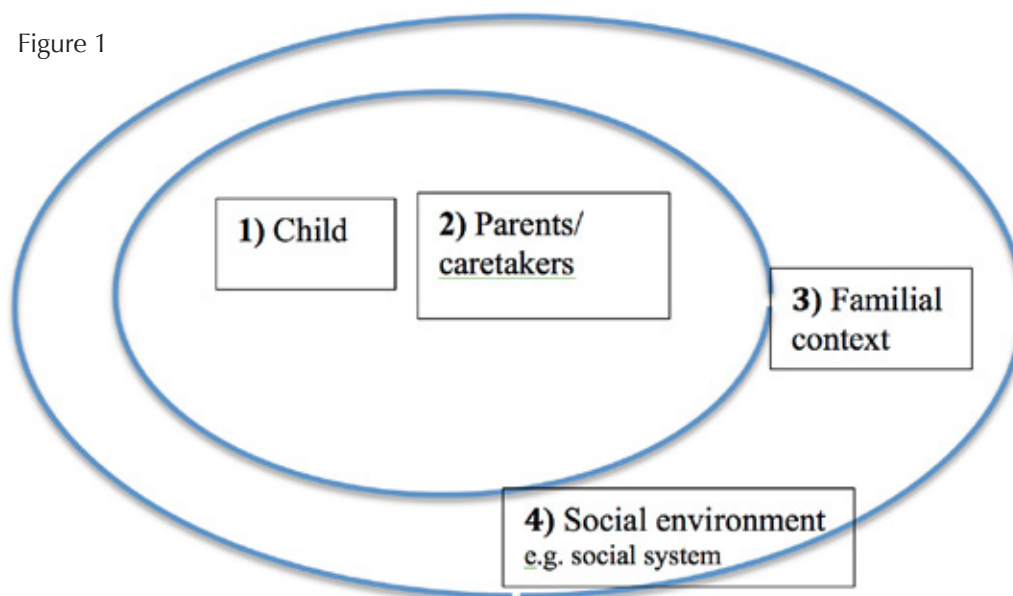
needs to be further examined in order to give the children the best possible life in the new country.

In order to prevent secondary traumatisation of children whose parents suffer from PTSD and to strengthen the resilience, I believe that informative and preventive interventions are needed for refugee families at their arrival to the new country. This should supplement already existing specialised trauma clinics, where the refugees can receive treatment for their mental disorders based on their previous trauma. ■

*Reference:*

1. Roth M, Neuner F, Elbert T. Transgenerational consequences of PTSD: risk factors for the mental health of children whose mothers have been exposed to the Rwandan genocide. *International journal of mental health systems*. 2014.

Figure 1





# The role of lithium in drinking water and suicidal behaviour

Vilma Liaugaudaite

Suicide is a huge public health issue determined by various factors that include psychiatric disorders and socio-economic and environmental issues. The World Health Organization reports that suicide is a major public health concern accounting for approximately 800,000 deaths annually worldwide, including approximately 58,000 deaths in the European Union and 900 deaths in Lithuania. Many countries are committed to developing prevention programs to reduce the incidence of suicide. To date, several strategies have been proposed for suicide prevention some of which may be pharmacological, both at the population and the individual level.

**Substantial data shows that lithium** will significantly reduce mortality in patients with mood disorders and reduce suicidality. Building on this evidence, some recent studies have investigated whether a relationship might exist between levels of lithium in drinking water and mortality rates for suicide in the general population. Although natural lithium intake doses are significantly lower than those used for the treatment of patients with psychiatric disorders, there is a growing evidence that even very low lithium levels induced by routine consumption of lithium from tap water may have anti-suicidal effects, both in patients with mood disorders and in the general population. One hypothesis explaining anti-suicidal effects of low lithium levels is that long-term exposure to lithium through routinely drinking ordinary water may counteract a low absolute lithium level.

## **Effects of lithium deficiency on behavioral parameters**

Lithium was detected in human organs and fetal tissues already in the late 19th century, leading to early suggestions as to possible specific functions in the organism. However, it took another century until evidence for the essentiality of lithium became available. In studies conducted from the 1970 to the 1990, rats



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and goats maintained on low-lithium rations were shown to exhibit higher mortalities as well as reproductive and behavioural abnormalities. In humans, defined lithium deficiency diseases have not been characterized, but ecological studies have found that low lithium intake from water supplies are associated with increased rates of suicides, homicides, as well as the arrest rates for drug use and other crimes.

Research shows that lithium occurs naturally in food and drinking water and may exert positive effects on mental health. Lithium acts on mood and suicidality via complex interactions with the serotonergic system, decreasing brain level of tryptophan and serotonin. The research shows the important role that testosterone plays in regulating mood and behaviour, making it a potentially important marker for suicide risk in an already at-risk population. The mechanisms of action of lithium appear to be extraordinarily complex, multifactorial, and strongly correlated with the functions of other elements, drugs, enzymes, hormones, vitamins, and growth and transforming factors. Although these changes have been mostly observed at pharmacological levels, they could also occur at nutritional levels, accounting for the unusually broad activity spectrum of lithium.

Lithium is found naturally in vegetables, grains, and drinking water. Nutritional studies suggest that lithium is an essential trace element with a recommended dietary allowance of 1 mg/day. Observational studies in Japan suggest that naturally occurring lithium in drinking water may increase the human lifespan. Lithium in therapeutic doses (usually, 600–1800 mg per day) is widely used for treatment of manic-depressive episodes, and it may be associated with reduced rates of suicide and suicide attempts in patients with bipolar disorders. A placebo-controlled trial data showed that low doses of lithium might improve and stabilize mood quite rapidly in former drug users. Endogenous lithium in the human body has been suggested to

have a physiological function, although sufficient evidence of this is still lacking.

#### **Epidemiological studies of trace lithium doses**

Throughout the world, lithium is detectable in drinking water at varying concentrations. Lithium concentrations in ground water vary between <0.05 to 150 µg/L. However, reports from Austria, northern Chile, and northern Argentina have shown very high lithium concentrations in drinking water (over 1000 µg/L). In temperate humid zones, the lithium levels in ground water are lower than in dry, hot regions (about 1500 µg/L). In most but not all studies, there is a negative relationship between lithium levels in drinking water and suicide rates. Thus, the natural lithium levels in drinking water correlates inversely with suicide risk.

There are no drinking water standards for lithium in the European Union, and we could not find any data of lithium concentrations in drinking water from the other Baltic or neighborhood countries. However, results from our pilot study showed that the lithium concentration in ground water from nine Lithuanian cities varies, ranging from 0.48 to 35.53 µg/L. This study showed that higher natural lithium levels in the public drinking water may be associated with lower a local suicide rate in nine Lithuanian cities. These nine cities represent 41 percent of the general population, and so generalization can be made. Thus, higher levels of lithium in public drinking water may be associated with lower suicide rates in males. It might be protective on the risk of male suicide.

In Lithuania, male suicide rate is 6 times higher than in females. This is consistent with recent metaanalyses, indicating that the female gender is associated with suicide attempts, while the male gender is associated with suicide deaths. Probably, men are more likely to complete suicide attempts because they choose more violent means of death. These gender differences may



be explained by the fact that natural lithium intake may influence impulsiveness, a factor that contributes to suicidal behaviour, and that men respond better to lithium treatment than women.

Evidence linking low lithium intakes with altered behaviour and aggression in humans has been reported by Dawson et al. These Texan authors compared regional mental hospital admission rates and homicide rates for 1967-1969 with the lithium concentrations in tap water samples and in urine samples obtained from 24 county sites. The strongest and significant inverse associations of water lithium levels were observed with first mental hospital admissions for psychosis, neurosis and personality disorders. The decreasing order of magnitude of the associations was neurosis, schizophrenic psychosis, first admission, all admissions, personality, homicide and secondary admissions. Lithium deficiency may not only be caused by low dietary lithium intakes but it can also be secondary to certain diseases. Organ lithium contents in kidney disease and, especially, in dialysis patients, approach deficiency levels.

Understanding the mechanism by which lithium acts to decrease suicidal behavior may lead to a better understanding of the neurobiology of suicide in males. Treatment of patients with suicidal behavior is one of the most challenging tasks for health-care professionals. The evaluation of risk factors associated with suicidal behavior, e.g. lithium in a local drinking water, might provide regional effective prevention programs. ■

# Gender differences in psychiatric morbidity

– an interview with Anne Høye

Ola Marstein

In the gender-sensitive environment of our times, The Nordic Psychiatrist wants to explore psychiatric morbidity in women and men. We turn up far north, to Associate Professor Anne Høye, MD, PhD at the University of Tromsø, The Arctic University of Norway. She is also involved in research at the Norwegian Centre for Clinical Documentation and Evaluation and at the University Hospital of North Norway.

*We ask the questions, starting with:*

**Which differences in psychiatric morbidity can be found between women and men?**

*Anne answers, rapidly, without latency:*

- There are small sex differences in overall rates of mental disorders, but the diagnostic distribution is very different in men and women when it comes to non-severe mental disorders. Women have significantly higher rates of eating disorders, depression and anxiety, and they also have higher rates of somatoform disorders and post-traumatic stress disorder. WHO reports that the prevalence of these disorders varies from country to country, but is higher for women across diverse societies. Depression, for instance, is almost twice as common in women in all countries. Men seem to be more prone to alcohol and drug related disorders. Generally speaking, women seem to have a higher degree of internalizing symptomatology, whereas the symptoms in men are more externalizing. This is also the case when it comes to distribution within the personality disorder spectrum. Also, men have higher rates of neurodevelopmental disorders such as ADHD and autism spectrum disorders, including Asperger.

The picture is somewhat different for psychotic disorders like schizophrenia and bipolar affective disorders, with no huge differences in distribution between men and women. Recent findings, among other Thorup's register studies in Denmark, do, however, point to a higher lifetime prevalence of schizophrenia in men than in women.

**What about age at onset of disease?**

- In schizophrenia, men are younger, they have more

negative symptoms, lower premorbid level of functioning, their social network is weaker and they have a higher degree of cognitive impairment. Some findings suggest that there are more frequent changes in brain morphology in men.

With regard to women's later onset, the question of a possible protective effect of estrogen has been raised. After menopause, the prevalence of psychotic symptoms increases in women. Whereas sex differences used to be attributed to the different age at onset and not a real difference, Thorup's studies show that the cumulative incidence is significantly higher for men.

Women's symptoms in psychosis seem to go more into the affective spectrum. Some studies show that women respond better to antipsychotic drugs, but also have more side effects. They are able to maintain a better social network, but we do not know precisely whether this is because of the later onset or gender linked differences in symptomatology.

The higher male risk of neurodevelopmental disorders, and the lower cognitive and psychosocial functioning in male schizophrenia, raises the question of whether men are particularly vulnerable to a possible genetic continuum between some neurodevelopmental disorders towards the schizophrenia spectrum.

**Do societal factors play a role?**

- Yes, and an important one, too! Worldwide, women have lower socio-economic status and a lower rank in many aspects, they suffer from discrimination and oppression because of their gender. This is a highly probable contributor to their higher prevalence of anxiety and depression.

Risk of psychosis is not so easily explained by these





**Anne Høye**

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mechanisms. The sex differences are not so distinct, and genetic or biological factors seem to play a greater role here than in the non-severe mental disorders.

Another factor is exposure to violence. Both women and men are victims of aggression and violence in war and armed conflicts, but women are on the whole more exposed to domestic and sexual abuse and violence.

Gender stereotypes linked to expression of emotions may of course also contribute to the differences between men and women, and affect both help-seeking as well as interpretation by health care workers. In many cultures there seems, for instance, to be a greater acceptance for the expression of differentiated feelings and emotions among women, whereas aggression and anger are feelings that are more accepted in men.

#### **The access to treatment – is it adapted to these differences?**

On a general basis we know that women ask for help more often than men do, but we have less knowledge whether or not they receive the help they need. Subgroups of women at risk may of course differ from the general pattern, abstaining from seeking help.

Persons of both sexes with severe mental disorders have a very high mortality from somatic diseases compared to the general population, but the risk is higher for men compared to women. Men also carry a higher risk for suicide and violent death. Women make more suicide attempts, and they also seem more prone to self-harm.

We need more research to figure out how to differentiate and “tailor” treatment, also between the sexes. For instance, young men may have huge problems that are not uncovered or fully recognized, whereas on the other hand a high degree of suffering in women may be considered “normal” due to societal gender stereotypes.

#### **Do the outcomes of treatment also differ between women and men?**

There isn't one single answer to that question, we have to look at the particular diagnostic subgroups and treatment options. Regarding schizophrenia, women fare better in the short and medium time frame. As mentioned, it looks like antipsychotic drugs have different effects on the two genders, and women seem to be more prone to side effects. Here too, more differentiated research is needed.

#### **Finally, do we see differences in society's prioritization between the genders?**

Gender conditioned interpretation of symptoms and impairments depend upon the patients' gender as well of the gender of health professionals. We perform our interpretations on the basis of what we know from our own lives and our own perspectives, as well as the expectations and pre-assumptions of the society in which we live.

Here in Tromsø, we made a study of the diagnostic practice in Norway and Arkhangelsk in Russia: Clinicians gave a diagnosis of schizophrenia significantly more often to a case description of a male patient than that of a female patient, with exactly the same symptoms and disease course presented. Whereas the effect of patient gender had a clear impact on diagnostic decision, we found no effects by clinicians' gender. Nevertheless, the bottom line is that we have limited knowledge about the effects of our own and the patient's gender on our decisions when it comes to diagnosis and treatment.

The WHO generally wants to highlight women's health, also in mental health care. No matter how important this is, it brings with it a risk of ignoring boys and men as a very vulnerable group in their particular ways. The gender dimension must get an impact on our thinking about risk and vulnerability along many axes. We need to think in a more sophisticated and differentiated way around prevention and treatment, based upon the variations in risk and course of illness between the two sexes. The sex and/or gender dimension is of course highly important in research. ■

# Environmental factors and suicide

– an interview with Ullakarin Nyberg

Hans-Peter Mofors

**The correlation between environmental factors and suicide can be viewed from different perspectives – the ones of persons with risk of committing suicide, and the ones of the clinicians working with people who consider suicide as a way out of their misery.**

**To learn more about this,** I met with Ullakarin Nyberg, chairman of the Swedish Psychiatric Association, and also a well-known suicide researcher.

– No doubt, more suicides would be prevented with a safer outer and inner environment. In societies where access to suicidal means have been made more difficult, fewer suicidal attempts are made by using the restricted method. Fire-arms is a well known example. We have to keep in mind that the act of suicide more often than not is based on impulse, and when barriers such as fences and doors in the subway system make it difficult to perform an impulsive act, fewer suicides occur.

– The effect is dual, says Ullakarin. One is by putting an immediate stop to the action of a person with a suicidal impulse. The other is that a society that values your life, that wants you and every other citizen to live, can help a person in distress to find strength in a difficult situation where you feel all alone, as suicidal persons do. That particular effect is extremely important and a lot of work remains to be done on a national level to show that suicides are not wanted. In that context, the importance of symbolic signals should not be underestimated – such as signs reminding people that there is help to be found. Many countries including Sweden have national strategies comprising information on many levels, but they need to be implemented and evaluated.

Different cultures regard suicide in various ways. In societies with a high individual focus, such as the Scandinavian ones, individuals are prone to expect themselves to find their own solutions to problems. This contrasts with cultures where you reach out for the aid of others. We call that a horizontal trust, and

consider it as a protective factor for suicidality. Silence can be devastating in times of mental suffering. We need to encourage people to talk about feelings and to seek help – rather than only looking for their own solutions and feeling ashamed when they are unable to solve their problems.

There are differences in help-seeking behavior between men and women, also in Sweden. Women more often ask for help compared to men, and depressive signs are better understood in females. As a consequence, 70% of all suicides in Sweden occur among men and this is an important area for improvement if we want to reduce the number of suicides.

The presence of alcohol and drugs heavily influences the suicide rate, since drugs lower the threshold of impulse control and increase mental suffering. People with drug abuse die more often after a suicide attempt and their suicidal ideation is more serious compared to people without an addiction. It is a known fact that social factors, such as employment status and economy, play a major role for the risk of suicidal behaviour.

## **What about the perspective of the psychiatrist?**

To many physicians, the risk of suicide among their patients is a stressful burden. We want to take responsibility for our patients and a patient's sudden death by their own hand is perceived as a failure, even when we have done everything we can to prevent it from happening. Most of us will look, and often find, things we could (or should) have done differently.

Having met hundreds of colleagues who have lost patients in suicide, I know the importance of processing and analyzing the suicide together with others who worked with the patient. When we share feelings of

guilt and responsibility with others, the total burden is easier to carry.

When we share our experiences, we can learn more about details such as suicidal communication that makes it possible to understand why the suicide occurred when it did. For instance, it is not rare that people who have decided to end their life will experience a relief, or absence, of anxiety once the decision is made. This can be communicated in many ways, such as organizing ones belongings, suddenly communicating feelings of love and gratefulness. Understanding more about what happened often makes it easier to go on and the knowledge can be used for understanding other patients.

Unfortunately, the way doctors deal with suicide risk today is far too often influenced by the strive to show that you did everything correct, which often will be reduced to the question about how we write medical records. For years, there has been an exaggerated belief in the use of structured methods to detect suicidality. Many colleagues find themselves using structured scales and documenting unnecessary information – in the end also to protect their own back – in the not very unlikely event of an audit from the social authorities. We know from experience and research that the best way of detecting serious suicidality is by encouraging the patient to tell their story, and together with the patient try to understand why suicide is perceived as a solution to problems, not by asking pre-defined questions.

Instead of relying on a structured interview method, we need to look for, and use, the narrative way of communicating with the patient. It is not hard to detect existential thoughts and this gives a deeper understanding of the situation. More energy should be put on supporting the patient and finding each individual's unique competence, looking for factors that will encourage them to go on with their lives. To find the pros instead of the cons and focus more on life than death.

■



#### **Ullakarin Nyberg**

Chairman of the Swedish Psychiatric Association. Ullakarin has many years of experience from research and clinical work, implementing knowledge about suicidology.

#### **Quotes**

"Earth provides enough to satisfy every man's needs, but not every man's greed."

**Mahatma Gandhi**

"The poetry of the earth is never dead."

**John Keats**

"You are the master of your destiny. You can influence, direct and control your own environment. You can make your life what you want it to be."

**Napoleon Hill. *Think and Grow Rich: The Landmark Bestseller – Now Revised and Updated for the 21st Century***



# Working as a psychiatrist in Soviet times

– an interview with Biruta Kupča and Mintauts Caune  
Elmars Terauds

Interview with two prominent Latvian psychiatrists:

**Biruta Kupča**, Associate Professor, Riga Stradins University, Latvia, and **Mintauts Caune**, Emeritus Professor, Riga Centre of Psychiatry and Addiction Disorders, Latvia

*Interview by Dr. **Elmars Terauds**, psychiatrist, Riga Centre of Psychiatry and Addiction Disorders, Latvia.*

*Translated by Dr. Liena Grauda, psychiatrist, Riga Centre of Psychiatry and Addiction Disorders, Latvia.*



**Elmars Terauds**

**Elmars Terauds: What is your main experience from the mental health system in Soviet times?**

**Biruta Kupča:** In Soviet Latvia, psychiatry was based on the practices of the German school and had a high level of clinical competence. In Soviet times, there were no contacts with European countries and all the clinical knowledge was acquired in Moscow and Leningrad (St. Petersburg). Practicing psychiatrists had little to do with politics. As I was working in a female department in Soviet years, I met almost no patients receiving treatment for political reasons or being sent to specialized clinics in Russia. In Soviet times, there existed a good cooperation among Latvian and Estonian hospitals and universities; I defended my doctoral thesis in Tartu.

**Mintauts Caune:** I would describe my Soviet-time experience as burdensome. My psychiatric career started in the 1960s after several years of practice as a neurologist. At that time there was no structured postgraduate education, we had to acquire the necessary knowledge and skills ourselves. The major problems included lack of financial resources for psychiatry, inappropriate hospital premises and excessive number of patients in the departments with patients lying on mattresses placed on the floors of corridors. Psychiatric departments were overcrowded and thick with cigarette smoke. The situation slightly improved when the first psychopharmaco-

logical agents appeared - Serpazil (containing Rauwolfia) and later chlorpromazine.

Psychiatric practice in the 1960s and 1970s was associated with the continuous attention from the Committee for State Security and surveillance of some patients. Three times I was invited to provide explanations to the State Security, for instance about a fylfot gouged into a tree bark or about a drainage system clogged during the visit of foreign guests. I was never a member of the Communist Youth Union or the Communist Party, and thus I had not been involved in politically shaded issues. I repeatedly refused to become a reporter, thus being forced to face obstacles placed on my scientific activities and my efforts to prepare my doctoral thesis on the biochemistry of schizophrenia. What I can appreciate from that time is the opportunity to learn from professor Snežneviskis in Moscow. He was an outstanding clinician with his views based on the German psychiatric school. The attitude of Western countries towards psychiatry in the Soviet Union was disapproving.

**Elmars Terauds: What are the main changes in the Latvian mental health system during the years of independency?**

**Biruta Kupča:** During the last 20 years we have experienced improvements in the normative acts regulating the field of psychiatry, protecting patients as well as ensuring patients' rights and human rights in general.



**Biruta Kupča**, works at Department of Psychiatry and Narcology in Riga Stradins University. She has worked at Riga Center of Psychiatry and Narcology for 60 years, mostly in the Open ward for depression patients, and the last 4 years in an acute female department. She is vice-president of Latvian Psychiatric Association.



**Mintauts Caune**, Eworking as consultant in Riga Center of Psychiatry and Narcology. During a long period he was a Head of Department of Psychiatry and Narcology at Riga Stradins university (earlier Riga Medicine Institute).

It would be wrong to claim that these norms impose more restrictions on practising doctors. An important fact to emphasize is that psychiatrists' political views nowadays have no impact on patients' clinical assessment or treatment.

During the state system reorganisation in the 90s, psychiatry suffered a crisis with a lack of financial resources, limited availability of medications and necessity to reorganize psychiatric care. By now, gradual improvements in the field of psychiatry have occurred, for example a reduced number of hospital beds, decreased number of patients per psychiatrist and further development of outpatient services. However, the burden of red tape has increased.

**Mintauts Caune:** The begging of the 1990s was a tough time. We experienced a lack of resources; the funding for inpatient institutions was reduced with no allocations assigned to outpatient services. But probably the most difficult task was to understand and borrow from European colleagues the experience in the organisation of psychiatric care service and treatment. The cooperation with the Bayreuth Psychiatric Clinic in Germany played an important role by providing an opportunity for 50 Latvian doctors and nurses to un-

dergo training during the 1990s. Based on this practical experience deinstitutionalization, decentralization and destigmatization was initiated.

**Elmars Terauds: What do you think about the attitudes towards mentally disordered patients in Soviet times and now?**

**Biruta Kupca:** If we compare the attitude towards patients now and before, it has not changed very much. Stigma is still an ongoing issue in society. In the past, stigma incorporated political meanings, but now it is mainly related to humanistic aspects such as fear from psychiatric disorders, lack of understanding, and poor awareness. We can still hear people using such words as "mad" or "madhouse".

**Mintauts Caune:** The main distinguishing feature during the last years has been the humanistic attitude towards patients. It was something we used to talk about in Soviet times but those were only words. It's important to mention that human rights issues are nowadays ensured by laws and are obeyed in everyday clinical practice.

**Elmars Terauds:** What are the possibilities for patients to choose treatment options, e.g. psychotherapy?

**Biruta Kupca:** During the last 20 years the role of psychotherapy in the treatment of psychiatric disorders has increased. However, psychotherapy is not available for all patients who need it. Not all patients can afford to pay for psychotherapy themselves. Currently, patients have an opportunity to choose among different psychotherapeutic approaches and methods and can make a decision to receive treatment by a medical doctor specialized in psychotherapy or to have a consultation by a psychologist. Psychotherapists from Scandinavian countries, France, Czech Republic and other European countries have significantly contributed to the development of psychotherapy in Latvia.

**Mintauts Caune:** Nowadays patients have the opportunity to choose the place where they want to receive treatment, the treating doctor, as well as the method of treatment. The weakest point of our psychiatric service is the limited availability of psychotherapeutic interventions and rehabilitation facilities. Despite the varied and individualized psychotherapeutic methods practiced in Latvia, psychotherapy is poorly available. Another problem observed in modern psychotherapy is the ignorance of the views of modern clinical psychiatry.

**Elmars Terauds: What are the major challenges for the Latvian mental health care system?**

**Biruta Kupca:** Considerable progress has been made in the field of psychiatric education in Latvia, opening up new opportunities to visit international congresses, undergo training and study abroad, follow the latest information, and submit publications for international peer-reviewed journals. Treatment environment of inpatient establishments has improved along with further development of outpatient services and rehabilitation facilities.

It is a challenging task to continue the development of various outpatient mental health services and to improve cooperation with social care institutions. However, the most important challenge is to be able to convince qualified early-career psychiatrists and psychiatric nurses to stay and keep practising in Latvia. Nowadays young specialists often feel forced to leave the country for financial reasons – I am happy that they can have successful careers and be highly appreciated as specialists abroad.

## Quotes

“What is the use of a house if you haven’t got a tolerable planet to put it on?”

**Henry David Thoreau, *Familiar Letters***

“Nothing has a stronger influence psychologically on their environment and especially on their children than the unlive life of the parent.”

**C.G. Jung**

“Creating a new theory is not like destroying an old barn and erecting a skyscraper in its place. It is rather like climbing a mountain, gaining new and wider views, discovering unexpected connections between our starting points and its rich environment. But the point from which we started out still exists and can be seen, although it appears smaller and forms a tiny part of our broad view gained by the mastery of the obstacles on our adventurous way up.”

**Albert Einstein**

“I do not teach anyone, I only provide the environment in which they can learn”

**Albert Einstein**

“It is necessary, in this world, to be made of harder stuff than one’s environment.”

**Aleister Crowley, *Moonchild***

**Mintauts Caune:** Latvia needs educated mental health professionals – psychiatrists and nurses as well as rehabilitation specialists. Further development of social psychiatry is necessary. The lack of specialists is especially felt in the field of gerontopsychiatry and the care of patients with multimorbidities. In Latvia, there is an unmet need for further research on the current mental health situation, the impact of different changes accomplished in the outpatient care, and the introduction of new treatment methods. Our current views are mainly based on the experience gained from the European countries. ■



# Child and adolescent psychiatry in Soviet Lithuania and now

— an interview with Virginija Karaliene

Ramune Mazaliauskiene

**Ramune Mazaliauskiene: What is your main experience while working in the mental health system in Soviet times?**

**Virginija Karaliene:** Sometimes people tend to think that during the Soviet times nothing happened; psychiatry in general was awful, and child psychiatry did not exist at all.

Child psychiatry in Lithuania, as in most European countries and as an independent discipline, started to develop in the 1970's and early 1980's. Child psychiatrists (at that time they were called "psychoneurologists") worked together with pediatricians and were dedicated to their specialty; they worked much more because they were driven by an idea, and because there was no unified system of services. Priority in those days was an accurate and correct "dispensarization" – how to follow the course and performance by long-term observation.

Already in 1962, the first and the only child psychiatry department was opened at Vilnius Mental Hospital. In 1976, changes in specialization occurred, and child psychoneurologists had a possibility to choose either specialty of child neurology, or child psychiatry. So, child psychiatrists "moved away" from child treatment institutions to psychiatric institutions and started to work with psychiatrists (mostly in regional mental health centers that were called "dispensers" at that time. Help for children was delivered until age 16; older adolescents were treated together with adults.

The main task of a specialist in the outpatient treatment institution was to identify the signs of mental disorder as soon as possible and send the patient to the inpatient treatment unit in which psychological investigations were performed, the diagnosis defined, and the treatment started. This could take a few months. The doctor working at an outpatient clinic could not define or change the diagnosis or treatment. For this reason the



## **Virginija Karaliene**

is a child and adolescent psychiatrist, head of Mental Health center of Karoliniskes outpatient clinic, lector at Lithuanian Educology University and mentor of the residents at Vilnius University Psychiatric clinic. She is a member of European Society of Child and Adolescent Psychiatrists (ESCAP) and International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP). She is the head specialist in the field of child and adolescent psychiatry in Vilnius area, appointed by the Ministry of Health. Her experience in the field of psychiatry covers more than 20 years.

patient had to be sent to the hospital or to a special commission of specialists (these existed at the hospitals). A nurse worked together with child psychiatrist at the outpatient institutions. Nurses made an “active observation” of the patients at their homes, followed their conditions and made notes of it in statistical forms.

Today it is difficult to evaluate what we – the specialists – actually did during the Soviet times. Even in those days, child psychiatrists saw the child as a whole, including psychological, biological and social aspects. Working together with logopedists (speech specialists) and child neurologists, we started to act as a group.

At the same time many child psychiatrists worked at special kindergartens, schools where they had a possibility to collaborate with pedagogues, schoolmasters, but also to know their patients, establishing a human relationship with them.

**Ramune Mazaliauskiene: What are the main changes that occurred in mental health system of Lithuania during the years of independency?**

**Virginija Karaliene:** When Lithuania gained its independence the law changed, and adulthood was defined as over 18 years of age. After this increase of age, the child psychiatry specialty was changed according to the practice in the other countries, and named child and adolescent psychiatry. So, attention grew of disorders in both childhood and adolescence. The services rapidly changed and developed. After decentralization of mental health services it “moved” closer to where people lived. Centres started to deliver integrated rehabilitation services in the field of mental and developmental disorders. It allowed identifying developmental disorders at the early development stages, organizing help, using early intervention approach, and preparing recommendations for training specialists. The possibility of inter-institutional collaboration appeared together with understanding that help is necessary at various levels, both in educational institutions, and at home.

Today we can be satisfied that many investigations were performed of child and adolescent health, and many scientific works were written and published. Child and adolescent psychiatrists started an intense collaboration with foreign colleagues and joined professional organizations.

**Ramune Mazaliauskiene: What do you think about the attitudes towards mentally disordered patients in Soviet times and now?**

**Virginija Karaliene:** Today we are happy that mentally disordered children and adolescents have more and more possibilities to receive long-term effective help, participate in training processes, obtain abilities according to their needs and join the community. Parents and foster-parents are happier as well, because they can return to their own occupation and creative work. In the Soviet Union, children were “behind thick walls”, “not seen”, and when they were not seen the problem of mentally disordered children “didn’t exist” (in those days the child was not allowed to go to summer camps if he or she has been treated in a psychiatric ward).

**Ramune Mazaliauskiene: What about the possibilities for patients to choose the treatment options, e.g. psychotherapy?**

**Virginija Karaliene:** As I mentioned, in those days the possibilities for choice were limited, so it was difficult to talk about psychotherapy. The availability of psychotherapy is limited even nowadays because resources given from Obligatory Health Insurance Fund are not enough.

**Ramune Mazaliauskiene: What main challenges does the mental health care system in Lithuania have?**

**Virginija Karaliene:** We should be happy with changes introduced in the service field, but there are still many problems in child and adolescent psychiatry. Our children in Lithuania do not feel happy, although data from the last investigations show a slight increase in happiness. There are painful consequences of emigration, as well as problems with suicides among children and adolescents, mobbing and violence. So, many things must be addressed. ■

# Interview with Henrik Day Poulsen

Marianne Kastrup

Henrik Day Poulsen is a specialist in psychiatry. He has served as European manager for Bristol-Myers Squibb 2005-2009 and subsequently as consultant at Psychiatric Centre Copenhagen 2009-2014. He has run a part-time practice from 2009. Today he works with his practice, and works as a consultant for Patienterstatningen (Agency for Patient Compensation). He has a regular column, "Opinion", in one of the largest Danish newspapers (Berlingske Tidende), has written book reviews for the newspaper and published several books.

## ***Don't question my professionalism***

**It appears that the question of maintaining a high degree of professionalism is the common denominator in your many activities?**

"Yes, and it is extremely important to me that those who criticize me – and of course that happens regularly – will not question my professional background and expertise. One thing is if they do not share my political views, which in itself is unproblematic. It is another thing if they let such differences colour their view and perception of what I write and insinuate that I have done a poor professional job. I have experienced that some colleagues over the years have, for example, not agreed to my conclusion in some psychiatric assessment – fair enough – and instead of recognizing that opinions may differ, they have claimed that I have not done a proper job.

That to me is by far the most unpleasant consequence of my critical attitude towards certain topics and of my political stance.



## **Do you see other negative consequences of your public image and writings?**

If you run a blog as I have done, you are inviting trouble in some sense. I am quite outspoken, do not hide my political point of view, nor my sexual inclination, or style of life in general. And this provokes many and they may write all kinds of unpleasant comments to what from my side was meant to be a serious contribution. I do not spend time on social media so in that way I avoid seeing a lot of these poisonous remarks.

## **You do not find that the prize is too high?**

If you participate in the public debate on a regular basis it is essential that you can stand criticism and expo-



sure. You should be aware of the rules of the game. If you tend to feel personally touched and violated, then do not enter the field as it comes with a prize.

I am quite immune to such kind of criticism. It is only – as already mentioned – when somebody accuses me for not doing a proper professional job that I feel hurt.

I have also witnessed demonstrations in front of my clinic and in front of the hospital where I worked. I suspect scientologists were involved. The issue was that I had spoken quite openly against the restrictions in the dosage of olanzapine that our employers had forced upon us. My concern was that being medically responsible for the treatment in an emergency closed ward with very disturbed patients, there were incidents where the allowed dosage did not suffice – I did not advocate huge doses in general.

But I find it problematic if doctors are not allowed to speak up when decisions involve medical matters and where you may actually have an opinion based on your professional knowledge.

I do not question that you must be loyal to your work place. Neither do I have any problem with an employer making a decision based on economic considerations, provided these are openly stated.

### **But why did you decide to become so much involved in the public debate?**

I believe that as medical doctors, we have an obligation to speak up publicly. We have an extended education and a deep insight in health issues and policies. I find that the medical doctor should be the central figure in the running of a ward and that we should be proud of our comprehensive understanding and insight.

I think that we could contribute more to the public debate. This debate would in many instances benefit our own expertise. Few have seen all layers of society as we have, and observed human beings in all kinds of situations. To me it is an obligation to use my knowledge also in societal matters.

From a personal point of view, I have often experienced benefits from my activities. Through my contacts, I have gained an insight into the work of other professions. Furthermore, I have had the pleasure of being invited to many forums that have given enriching experiences. ■

### **Quotes on context and environment**

#### **Environment/context (professional – psychiatrist):**

"The psychiatric interviewer is supposed to be doing three things: considering what the patient could mean by what he says; considering how he himself can best phrase what he wishes to communicate to the patient; and, at the same time, observing the general pattern of the events being communicated. In addition to that, to make notes which will be of more than evocative value, or come anywhere near being a verbatim record of what is said, in my opinion is beyond the capacity of most human beings."

**Harry Stack Sullivan**

"We live in a moment of history where change is so speeded up that we begin to see the present only when it is already disappearing."

**R. D. Laing**

"I don't know why we are here, but I'm pretty sure that not in order to enjoy."

**Ludwig Wittgenstein**

# A man walking his own way

– a meeting with Anders Hansen

Hans-Peter Mofors



**We have never met, but I recognize him immediately from television, as he enters the café in central Stockholm. Anders Hansen is a psychiatrist in his forties. For some years he has been seen everywhere in media. Anders is interviewed in newspapers, television and radio. He writes books on neuroscience, spreading his message with enthusiasm and clarity.**

“Reading about science is the best I know,” says Anders. It is clear that he loves to talk about this. His fascination with human existence and consciousness. He sees clear evolutionary connections with our behaviour in everyday life and also to an increased psychiatric suffering in the general population.

– The brain has not kept the pace. It is still at the same level where we were thousands of years ago. Survival and prosperity were then linked to physical activity. Once we have transitioned to a sedentary lifestyle,

symptoms arise when our physiology does not relate well. It concerns stress systems, sensory input, and so much more.

Interest in writing started early. Anders first studied economics at the Stockholm School of Economics. Soon he began to work as an analyst on a daily newspaper. Here he learned the importance of expressing himself distinctly and simple.

Despite good work in the consulting industry, something was lacking, especially science. Anders

started studying medicine and soon got stuck. He continued to write, but now about science in a medical newspaper.

"Over the years I have read thousands of scientific articles. Learned to review them. My passion has been to convey science in a short and comprehensible way for a broader science circle, even to doctors who do not do research or have knowledge of specific specialties."

The clinical course began within cardiology, but Anders experienced that care was all too structured. All patients were to be examined following the same protocol. His choice fell instead on neuroscience and psychiatry.

Physical activity is good for health. Everyone knows this. But the link between cognition and health is, in principle, unknown to most people, despite extensive scientific evidence. After his first book "Prescription for health", which deals with the impact of physical activity on health in general, Anders decided to write a book about the connection between CNS function and physical exercise. The release of "The Real Happy Pill" has truly made Anders known to the general public. The book has been a tremendous success, and has now been translated into fourteen languages.

His latest book "The ADHD benefit" problematizes the concept and the risk with categorical diagnostics. Many people with ADHD may actually benefit greatly from it. Anders is looking seriously at the increased use of diagnoses of psychiatric conditions in the population.

In parallel, Anders participates every other week on television, where he answers viewers' questions about psychiatry. In addition, and together with his colleague Simon Kyaga, he runs a popular pod about science. Together with Simon, he travels to congresses all over the world and interviews famous scientists and then reflects on these meetings in the pod, which today are followed by hundreds of thousands.

The media attention has only had positive consequences, says Anders. Every day he meets people who tell how their self-image has changed after listening to him. Even colleagues give positive comments.

"I have always wanted to go my own way, and I'm happy with that," says Anders. I perceive myself as a strong individualistic person and feel a strong need to be myself, both in appearance and behaviour. Despite a rich social life, I have never felt the need to fit into any group affiliation.

Anders, who lives in central Stockholm, hopes that the future will continue just as it does now. He likes to combine various assignments. Nowadays, he works clinically one to two days a week. Other times he writes, lectures and devotes himself to desktop work. A fourth book is on its way, but he cannot yet reveal too much about the content. – But, it's about the brain. ■

#### **Quotes on context and environment**

##### **Environment/context (mental disorder and treatment):**

"A clean environment is a human right like any other. It is therefore part of our responsibility toward others to ensure that the world we pass on is as healthy, if not healthier, than we found it."

**Dalai Lama**

"When the flower doesn't bloom you fix the environment in which it grows, not the flower."

**Alexander Den Heijer**

"Nothing has a stronger influence psychologically on their environment and especially on their children than the unlived life of the parent."

**Carl Gustav Jung**

"Addiction, obesity, starvation (anorexia nervosa) are political problems, not psychiatric: each condenses and expresses a contest between the individual and some other person or persons in his environment over the control of the individual's body."

**Thomas Szasz**

"Love and work are to people, what water and sunshine are to plants. "

**Jonathan Haidt**



# Media and psychiatry from a science journalist's perspective

– an interview with Ulla Järvi

Hanna Tytärniemi

## **Why does health interest you in your work, and not some other subject?**

I wrote a lot about health subjects during my years in newspapers before I joined the Association of Finnish Health Journalists. Several organisations and associations were training journalists to write about medical issues in the 1990's. While working with the Finnish Medical Journal, I became interested in the ethics in health journalism. I wondered why many articles repeat the same pattern: the doctor is the main character of the interview, patients and their experiences come second and symptoms are described merely as a biological phenomena, disturbances in the "human machinery".

## **What kind of attention do psychiatrists and psychiatry have in the media? Is this somehow different from other medical specialities? Are there differences between Nordic and Baltic countries?**

Psychiatrists are often asked to give comments about people's deviating behaviour. This does not always concern psychiatric illness but also, for instance, criminal behaviour. Just recently in the autumn of 2017 there was a possible terrorism-linked attack in Turku, Finland. After this attack it was the psychiatrists who were asked to give their views about the causes, which can lead to violent behaviour. There was a possibility to discuss some less medical and more social issues such as the differences of violence and terror or what could be done to prevent radicalisation among asylum-seekers.

In Finland, psychiatrists are also interviewed about well-being and people would like to get simple guidelines for happiness and a good life. In other Nordic countries it is often not only medical doctors, but also other professionals, such as psychologists and sociologists, who are being interviewed about well-being and mental health. On the other hand, in the Baltic coun-

tries, medical professionals may even want to draw a clear line about commenting only on medical issues, instead of sharing their views about "a good life". In the Baltic media, there may be more articles based on "rubbish" as compared to Finnish media – they say people should have their own way of choosing what kind of articles or interviews they would believe in.

## **How can psychiatrists benefit from media attention? Is there a need for seeking benefits?**

Media is an essential arena for public discussion and open interaction between people! Even today, we don't have final answers about which cures or life choices are the best for human health. I wish that our media doctors would learn to adopt an interactive role allowing open discussion of different views about sickness and health. Psychiatrists, similar to other doctors, have a long university training and many of them work in the public health care or in the field of research in the universities. It should be an essential part of their work to educate the population and share proper information.

## **Psychiatry and stigma – what is the role of media there?**

For several decades psychiatrists and journalists have co-operated in diminishing stigma, which unfortunately is still present. My thesis (Jyväskylä University, 2011) showed that health journalism has diminished stigma around sickness and has also prepared doctors as well as patients to communicate using a language that both share. People's awareness is extremely important in the prevention of psychiatric illness as well as improvement of patients' status in the society. For example, in Finland there is a much more open discussion about depression than in the 1980's. The Finnish ethos includes the concept of diligence, thus the term "burn-out" has been commonly used to describe

depression and other fatigue syndromes. Yet more difficult psychiatric illnesses, such as schizophrenia, are still affected by stigma. There is a need for psychiatrists and journalists to work together in this area for health education campaigning.

**Especially social media and the yellow press often distort and aggravate psychiatry-related topics. For example, there is a lot of exceptionally negative attention on psychiatric medication in this kind of media. How can psychiatry compete against disinformation?**

It is important to differentiate between critical discussion and false information. Negative media attention does not always mean distribution of false information, and sometimes there is genuine interest for public discussion. I believe it is more important to learn the kind of discussion convention that emphasizes listening and attempts to understand different views, instead of building frontlines and keeping own positions. We Finns are not as good at this as the neighbouring Swedes, who manage discussion better – like they say “Vi måste diskutera!”

**Sometimes certain individual cases draw a lot of media attention, for example based on an interview with a single patient. Professionals who are concerned with the case have no chance for public comments because of confidentiality obligation. How could one-sided information be avoided? Are there possibilities for common discussion between psychiatrists and patients in the media?**

Journalists should always remember not to draw generalized conclusions from single cases. This means ever more challenges for journalists and a lot of pressure at work. The pace of work has grown immensely, and a journalist may have a deadline as high as 15 articles per one work-shift! Media administration is interested in how articles gain readers on the internet. Therefore there is a growing risk for going astray, putting too much value on “click articles”. It would be a dangerous development if the editing offices would value the most those articles that draw a lot of attention and sensation.

Disinformation is sometimes behind media sensation, so it is important for psychiatrists to follow the news in this field. I recommend psychiatrists to contact editorial offices when there is a need for correction of false information. Most European media agencies have engaged Good Journalistic Practices, which includes correction of errors.

It is good to remember that in most countries, including Finland, a doctor may comment on a single

patient case in public, provided the patient has given a written consent. This is often forgotten and, of course, psychiatric cases demand especial ethical consideration. It is different to give comments on the surgical repair of an athlete's Achilles tendon than on the psychosis of an actor. If there is a disagreement involved, it is not possible for a doctor to give correcting information to the public about a single patient case. However, it is possible for organisation superiors to publicly defend their organisation and employees from unreasonable offences.

**Lack of psychiatrists is an international phenomenon. How is this approached in the media? Are there any means of marketing psychiatry as a speciality among young doctors?**

What a good question! People of all ages are interested at other people's tales of “how I became me”, and how they have progressed in their careers. Psychiatry may not contain that many “hero tales”, but psychiatrists could tell more about their careers, the ordinary practices of psychiatric hospitals, new treatment possibilities, and so on. I'm sure there is a call for young doctors in this speciality and it is important to remember that today's youth is accustomed to use wholly different kinds of media than before. Blogs and video blogs (vlogs) are a chance to approach the youth. Therefore the early career psychiatrists should be encouraged to be present in these new media channels. Understandably health care is a delicate area for open communication, but hiding from publicity is also hiding the good issues. I support responsible openness!

**What kind of a psychiatrist is eligible for media publicity? Who is competent enough to give interviews or write columns in magazines? Is there a way to differentiate between professional and private opinions?**

First of all, it is good to remember that it is not possible to differentiate private and professional roles in the media. Therefore it is advisable to appear in the media in a way that is natural for one self and give only a message that one can maintain anywhere. Experienced media professionals emphasize that one can learn media appearance only by doing it, so one can never be totally “ready”. At their best, interview situations with a journalist involves a training to summarize one's message and transmitting good experience about media appear-



**Ulla Järvi** is a Finnish science journalist. She is Secretary General of The Finnish Association of Science Editors and Journalists (FASEJ). Järvi has worked as a reporter in newspapers, as a medical journalist in the Finnish Medical Journal and now in FASEJ. FASEJ is one of the largest member associations of the European Union of Science Journalists' Associations (EUSJA) forming part of the Finnish collective copyright system and representing over 1100 science writers' rights. As

an active science popularizer, Järvi has also written books about women's health. She has published academic research and books about health journalism and science communication. Järvi was chair of the Programme Committee of the 8th World Conference for Science Journalists in Helsinki 2013. She has been a member of Finnish Mass Media Council and a part of several communication advisory boards of Finnish patient associations and medical organizations.

ance. If you feel that your message has been distorted, it is good to prepare for the next time – how to mediate the message so that misunderstandings would not arise.

Doctors, especially female doctors, have a professional habit of self-criticising or underestimating their

knowledge. It is acceptable for a doctor to mention his or her limited know-how or limited medical knowledge on certain issues. One can also present experiences from his or her own clinical background – even colleagues cannot argue with individual experiences. Doctors should also learn to be more friendly toward



a colleague showing up in the media. Appearance in the media does not necessarily mean seeking publicity, but rather having been searched and approached by the media. So next time your colleague appears in the media, offer praise and encouragement, do not belittle or ridicule.

**Is there any way in which psychiatrists in the media could avoid their opinions from being distorted and attacked? What is to be done if media attention turns against yourself?**

There are organisations that supervise media business in the Nordic countries. You could contact the Mass Media Council or corresponding organisation in your country. Corrections of errors is genuinely considered to be a matter of honour by the media business. Even so, there are sometimes disputes about how issues have been presented in the media and whose ideas and claims have been presented. You could contact the Editor-in-Chief and present your own view about the issue. You could also present your message in the opinions page of a newspaper.

If negative publicity or even hate-speech in the social media is targeted against you, it is important to contact your superior and tell about what has happened. Today, each organisation should have written guidelines about how to act if an employee has been attacked with hate-speech. When is it time to contact the police? – they can usually evaluate what kind of a threat is really dangerous. This is an important matter of work safety! There are Finnish inquiries showing that, unfortunately, hate-speech towards scientists and professionals has increased. Therefore it is important to have clear guidelines on how to act.

On the other hand, positive feedback has also increased because of social media! I believe that in the following years we will learn to adopt good policies in the social media. After all, we have always had to learn how to use new media channels – the same has happened earlier with the telegraph, radio, and television.

**Our journal's recent issue is about Environment – all aspects included. What do you consider most important about environment?**

Psychiatry once was a secluded subject inside asylums, but today it has become so much more open to the public. Psychiatric patients used to be locked-up inside mental institutions even for decades, and hospitals were big, secluded communities. As outpatient treatments have increased, psychiatric patients are now around us in the streets, shops, work places – and in the media. Psychiatric professionals, nurses and doc-

tors included, should remember that this new opening has drawn more and more media attention towards psychiatric patients. The social media creates a totally new environment for discussion of psychiatry and psychiatric illness. Patients have internet discussions about their medications and therapies, and they often ask and give their advice and opinions about medication. This kind of peer support is extremely important but poses also risks that professionals need to be aware of. So it is important to be somehow present in the social media – maybe someone from each work place could be selected to follow what goes on in the social media discussions. This kind of appearance in the social media could help preventing false information and sensations from being spread.

At the moment, there is a lot of discussion among science journalists about environmental risks and environmental hypersensitivity – and is it always ethical to report these issues. Do we increase unnecessary worries or fears by discussing cell phone radiation, wind turbine effects, mould houses and so on? It would be good for psychiatrists and journalists to meet every once in a while to discuss these kind of current issues and phenomena. Mutual understanding and interaction could prevent or stop futile media sensations. ■

# Young males and suicide

Óttar Gudmundsson

The last decade or so has seen the suicide rate in Iceland increase from 27 (in 2011) to 49 (in 2013). This constitutes 12.1 suicides per every 100,000 inhabitants during the period in question, but it also illustrates considerable fluctuations between the years, which are due to the small size of the Icelandic nation. This is similar to the suicide rate in Iceland's neighbour countries. The last decades have seen but small changes in terms of the age and gender distribution within this group. Female suicide (3.1-8.7 per every 100,000 inhabitants) is significantly more rare than that of men (13.7-22.5 per every 100,000 inhabitants), which compares with the suicide rate in other Western countries. There is a gender gap in the age distribution of those committing suicide, as quite a large group of young males aged 20-30 take their lives every year, whereas suicide is still rather rare among young females.

In 2000, the number of suicides in Iceland was 53, with 8 young men (aged 18-24). This generated the launch of a special campaign and the establishment of a special group of professionals. Visits were made to various parts of Iceland with a main focus on educating health personnel, teachers, members of the church, and social-service personnel. The goal was to identify and report on the symptoms that frequently precede suicide in order to facilitate any available intervention.

Unfortunately, the campaign lost its wings some five years later, due to lack of funds. Suicide by young males continues to be a major problem but reducing the suicide rate proves difficult. Iceland is a small and close-knit society. Very young males taking their lives at the peak of their existence draws much attention and causes dread and dismay. The whole society knows about such incidents and the funerals of these young men attract attention and create sympathy.

Usually, suicide by adults is a process that may go on for several weeks, months or years. The individual is usually depressed with low self-esteem, and gradually begins to toy with the idea of death as a friend or the only available solution. Such thoughts about death frequently become very constant and the person begins to think about how to speed up his or her death. Gradually, some kind of a plan begins to form and settle in the consciousness. At this phase only a small stimulus may push a person over the edge. Alcohol consump-



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tion is a risk factor. Two thirds of all those committing suicide are under the influence of alcohol or other in-

toxicants. Many live in the shadow of social problems, unemployment, and social isolation, or have suffered traumas causing major changes in their social circumstances. The goal of the preventive attempt from 2000 was to teach health personnel and others to recognize this development in order to enable them to intervene, one way or the other.

The problem with young males is that their conduct often does not follow any lines or developments normally experienced by adults. They are bolder and frequently make only one attempt – and they succeed! The problem regarding prevention for this particular group is to identify those who are at special risk. A predominant factor among some of these young men is that they use intoxicants and have social problems. Their schooling is usually finished and finding their place in the community frequently comes difficult. They are often unemployed or live under some work-related measures. These young males frequently experience feelings of inferiority towards their female peers, who seem to do better in footing themselves in their studies or in the labour market. Friendships between young men do not appear to be as close and deep as friendships between young women.

These young men are frequently isolated and have only a few friends in whom they can confide their feelings. They often flee into the world of computer games and cannabis smoking, becoming even more isolated.

These young men have developed a profound sense of hopelessness about how nothing will work out in their lives.

This scenario, however, certainly does not apply to everyone. A group of these males are doing fine in life and their suicide thus comes as a total surprise. The problem of the healthcare system is that these young men rarely seek help. They deem that no one can help them; hence they grit their teeth and continue to isolate themselves. They remain unidentified in the healthcare system or the open wards of the psychiatric clinics. In recent years, various other measures have been tried to reach them but so far there is not enough experience.

The knowledge about suicide and how to prevent it has increased. There exists much knowledge about the conduct of people who are in a suicidal phase, but reaching them has been difficult. Major changes have occurred in communications through the development of the social media in recent years. Taking this into account is very important, being a major challenge in future preventive measures against suicide. ■



# Experiences with "package tracks" in mental health care

– an interview with Karin Wang Holmen and Kathinka Meirik  
Ola Marstein

The Norwegian Directorate of Health has initiated a great programme of "package tracks" in mental health care, inspired by similar endeavours in Denmark, both for cancer and for mental health. The Directorate is this autumn in the middle of launching a series of programmes for different conditions, and did not have the opportunity to answer our questions. So instead, we turn to the county of North Trøndelag in the middle of Norway, where local professionals and leaders have pioneered the same ideas into practice.

We look to Levanger, not far from Stiklestad where the Viking king, later Saint Olav, fell in the battle of 1030. Historical grounds, you see.

Our guides are two psychiatrists: Head of clinic Kathinka Meirik, and Head of department Karin Wang Holmen:

In our Regional Health Authority, "Helse Midt-Norge" (Health Middle Norway), we use the term "patient track". Here in our county clinic we have designed separate patient tracks for psychotic disorders, bipolar disorder, and ADHD. In addition, we have participated in the regional work with tracks for acute intoxication, psychosis and eating disorders in adults.

## **What got you going, and when did you start?**

We started in the autumn of 2014. Our motive was a wish to safeguard access to services for those patients that needed it the most plus the need for improving "patient flow" and reducing unwanted variance. The Danish experiences were known to us, and they were a great inspiration. Also, the Regional Health Authority wanted such patient tracks as a principle in our work.

## **Did you have any reservations?**

Oh yes. Some colleagues worried that the assessment and treatment would become too structured, preventing the staff from meeting the individual patients' needs. The method in constructing the tracks was new to us, and it was tempting to wait for others to test it out first. On the other hand, this also was a motivation in that it allowed us to influence the design and content of the tracks.

## **Who were the local "motors"?**

Many of our clinicians were interested in participation. Karin was very keen to prepare a tool for adults with ADHD, a condition with very great variance in services. We had a guide for the disorder, but it did not say much about the standard of services. This led to each clinician doing it his or her own way, and this needed improvement – and standardization of services.

We also had a person in place that knew the methodology in designing such tracks and who could assist the mental health professionals. These were then relieved of the pure methodology, and were freer to concentrate on the content.

## **What are your experiences?**

For the patients with ADHD, our services are now more comprehensive. They are presented with a step-wise track for assessment, which is the same regardless of which therapist they meet. The treatment course is sketched out from the outset. In addition to drug treatment, every patient is offered an "ADHD school" – a psychoeducative service to every adult patient with ADHD. This has been highly appreciated by the patients and their relatives. In all, the feedback from the users is very positive.

The process of designing the tracks itself has also been a positive experience. Clinicians find it meaningful and exciting! The user representatives have come up with very useful and important contributions. However, we had to search a good deal around to find



**Karin Wang Holmen**

fruitful models for involving general practitioners and municipalities, who are responsible for the community health services. We are still uncertain when it comes to how committed the GPs see themselves. This will be interesting to see when the new national guidelines are ready for implementation.

Until now, we have not had the efficient IT tools that we need to gauge if we actually do what we have decided to do in the patient tracks. Our staff wants feedback on how they themselves and their patients perform, and lack of tools is a great source of frustration. We hope that these tools will become part of the national tracks!

**Do your patient tracks have any impact on access to services?**

Not yet. We follow the national guidelines for priority setting. But the patients have given good evaluations of the tracks to us, and they recommend the service to their friends with similar problems. So the amount of referrals has not decreased!

**Do you see any effects on the quality of the outcome?**

Our clinic has focussed on standardized assessment tools and evidence-based treatment procedures for many years. "Thanks to" inferior IT services we have



**Kathinka Meirik**

had trouble extracting objective data for change in clinical practice. However, we can see that the number of admissions for acute mania has been reduced over time. This has been interpreted to imply that clever patient tracks with assessment and evaluation, treatment and psychoeducation, crisis plans, etc., has led to changes in the patient population with bipolar disorder. Our clinical impression is that crisis planning and good psychoeducation and information to both patients and their families is essential. The patient tracks contribute to safeguard that every patient has access to these services.

Our discipline still lacks efficient tools for assessment, and it has no biological tests that can produce diagnostic answers with high reliability. Therefore, patient tracks will be able to confer a significant quality improvement. There are many "schools" in our field, and we need to agree on certain areas where we can implement minimum standards for assessment and treatment, within borders for which conditions to treat, set by the guidelines for priority setting.

In order to improve the prognosis for patients with the most serious disorders in psychiatry, namely psychoses and bipolar affective disorder

(but also addictive disorders), it is of the utmost importance that those treatments with the best evidence are implemented. Our patients deserve being able to demand such effective treatments. Somatic health has its own crucial place in our packages for mental health. Psychiatry has not done so much in this respect!

**What consequences do the tracks have for competence and education?**

We can more easily see that we speak about the same thing, now that we share these tracks. The clinicians want all patients to receive the same services. In particular, this is the case for bipolar patients.

Moreover, it is easier to educate and teach new staff with a good patient track. And good and explicit standards are the best way to compensate for lack of trained personnel. It ensures a minimum of good assessment and treatment. Many of our staff have moved to other clinics in Norway, and they report back to us that they miss our structure and good routines for many patient groups. Without such routines, training is difficult, and this leads to insecurity in coping with all the challenges that arise in an outpatient clinic, where one is working on one's own.

Our clinicians say that designing our tracks is inspiring for them as professionals. All the time, you have to think in terms of time and "patient career", not only the very small individual contribution. One must be familiar with guidelines and frontier research.

So far, the early career residents and psychologists have not participated in our working groups for tracks, but we can see that such work is a good "learning arena". This holds both as a part of the new national training modules for medical specialists in Norway, and also as a means to involve more staff in quality and improvement work.

**Which are the economic consequences of these patient tracks?**

This, too, is not yet known. They may yield more treatment for the same amount of money, and we see that the tracks are a very good support for clinicians at work. Everything that eliminates disturbance and "bugs" is added value, and is certainly also cheaper!

**Do you see any areas where patient tracks are not suitable?**

This depends on how "tight" such tracks are conceived. The Danish model has its weaknesses, and the Norwegian national model has not been tested yet. We can stipulate that persons who need long term and individually tailor-made treatment will profit greatly from having specific measure points for evaluation. We are curious if it is possible to make good tracks for diffuse conditions, such as those patients that "fall between all chairs". Still unknown!

**What is next?**

First, we will implement the national tracks, and crucially, install IT tools which will enable us to measure what we say we will do. Then we have to find out how to handle our local tracks when the national tracks are launched. And not least: the tracks must help us to better collaborate with primary care in the municipalities, both during and after specialist care.

Finally, we have some challenges in our own clinic. There are still differences in diagnostic practice between units concerning bipolar and personality disorders, in spite of the same patient groups. This has to be looked into! ■



# Change of paradigm of mental health and well-being in Lithuania

– an interview with Egle Sumskiene

Ramune Mazaliauskiene

**Ramune Mazaliauskiene:** You and colleagues performed an investigation supported by Lithuanian science board, named “The change of paradigm of mental health and well-being in Lithuania: towards an empirically valid model”. Why is this investigation important for the Lithuanian mental health system?

**Egle Sumskiene:** First of all there is a necessity to evaluate the systems orientation to the results. Today main attention is paid to the components of the process or resources, such as the number of psychiatric beds, the quantity of the psychiatrists and nurses, morbidity, and the expenses spent for one day of hospitalization. There is still little interest in what are the achievements of the functioning of the system, and what changes have come into action. This is evident when talking about suicides – we know about the high rates of suicides, we know what kind of preventive programs we perform and how we finance them, and we know the problematic regions and sociodemographic characteristics of people who are at risk. But this knowledge does not change the situation. We work in a passive way, we do not evaluate and analyse what really works, and what does not work, and why. This gap in evaluation and analysis was what we tried to overcome.

In the project, we tried a holistic model and created a complex model for evaluation. We included quantitative and qualitative information, perspectives from the patients, experts and staff, as well as economic, sociological, and psychological aspects. The data were collected using ten different instruments, and 25 investigators joined over time. The mental health system of Lithuania has never been evaluated with such an abundance of instruments and investigators.

Our investigation gives concrete arguments and offers evidence-based information on psychotherapeutic and medical treatments, the effectiveness of social and rehabilitation services in the process of integrating persons with psychosocial disability into the labour market, as well as the extent of economic burden, faulty

priorities in financing, and the weaknesses in attempting to prevent.

**Ramune Mazaliauskiene:** What were the main messages?

**Egle Sumskiene:** Discourses on biomedical issues and crime stories predominate in the mass media. The group of people focussed upon are non-independent individuals in need in of continuous services, using the resources of the society. However, foul and offensive statements in mass media have diminished – we found few exceptionally negative terms. The economic burden due to mental diseases has become heavier and we also noted an increase of the expenses for compensated drugs and treatment of co-existing illnesses.

Direct non-medical state expenses are low due to poor delivery of necessary services (e.g. rehabilitation, occupational aid, social services). This, in turn, will produce a significant loss of life years, an increase in the level of disability of mentally disordered people, and a lowered income.

**Ramune Mazaliauskiene:** You asked specialists working in the mental health field. Did they give you some insights concerning attitudes towards treatment of mental diseases and the change of socio-economic and cultural factors occurring in the last 10-20 years?

**Egle Sumskiene:** In spite of a dynamic change of social, economic and cultural factors, the attitude towards mental disorders has not changed much during the last decades. It is difficult for innovations to get anchored into the system. For example, mostly elderly psychiatrists work in the regions, and they oppose any novelties. Being the leaders of the treatment teams they set unchanging attitudes towards the patients and their rights. On the other hand, younger people who work in bigger



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Egle Sumskiene is a social worker, a sociologist and expert on disability, mental health and human rights issues. She completed her Ph.D. on the topic "From traditional to modern care: case of persons with psychosocial disabilities". Since 2002, Egle Sumskiene works at Vilnius University Social Work department as a lecturer, and in 2012 she took on a position of Associate Professor. Sumskiene is actively working in the Lithuanian NGO sector, focussing on mental health and human rights. During a period as an expert, she was involved in various international and national projects focusing on areas such as human rights and disability, discrimination, mental health care, policy, and social integration of people with psychosocial disabilities. She is the editor of one monograph and the author of over 20 scientific publications, covering issues of human rights and mental health.

cities are more ready to test new things – they study and deliver psychotherapy and are guided by different attitudes towards the patients as well. Hospitals may try innovative services and re-distribute resources inside the institutions, but the existing financial model prevents delivery from being profitable.

**Ramune Mazaliauskiene: What was the opinion of the specialists who evaluated the socio-economic and cultural context of the origin and treatment about the on-going (or not on-going) changes?**

**Egle Sumskiene:** Most often initiatives from "below" were emphasized, in opposition to the inert thinking from "above". There is no general atmosphere favouring change at the political level, and single initiatives will not affect fundamental systemic changes. Financial managers make the decisions, and they are not so interested in treatment innovations and modern attitudes towards human rights. This strategy will save money for now (e.g., psychologists working at primary mental health centres receive minimal salary), but our experts consider the long-term negative consequences for the system and for Lithuanian society.

**Ramune Mazaliauskiene: I have seen the results of your project and noticed that the attitudes of specialists and patients differ as for medical treatment and psychotherapy. Could you comment on this?**

**Egle Sumskiene:** Actually, there were no big differences in attitudes. Specialists and patients agreed when evaluating specific treatment methods and their advantages. Psychiatrists preferring psychotropic drugs have the necessary knowledge and information, but according to our investigation, they prescribe inappropriate treatment since they are not able to prescribe available psychotherapy. "I had to do something, so I prescribed..."

**Ramune Mazaliauskiene: What are your recommendations to those following a modern model of help to those suffering from mental disorders?**

**Egle Sumskiene:** It is necessary to review and correct the existing system of monitoring in mental health care, extending the existing quantitative indicators that are oriented towards resource and process monitoring. In monitoring, special attention must be paid to evaluate the activity results of mental health system.

It is necessary to seek more rational distribution of state resources when treating mentally ill persons. Analysis of direct state expenses have uncovered a rapidly increasing economic burden, most probably due to the fact that the Compulsory Health Insurance Fund is oriented towards covering the expenses of in-patient and mainly active treatment, as well as compensation for psychotropic drugs. The situation can be improved by investing in economically effective forms of services and integration of help.

In our investigating patients and experts, we could

see that inadequate payment for psychotherapeutical and psychological services left the institutions unmotivated to deliver these services. Data on services delivered in private mental help institutions are imprecise and are not included into official statistics. However, these services must be available to those who are treated in large mental health care institutions or to those who can pay private providers, since they are a significant part of services that are to be delivered at mental health centres.

Integrated treatment is recommended, providing for various forms of psychotherapy combined with medical treatment. Moreover, the evaluation of the efficacy of different treatment forms (medical, psychotherapeutical, and mixed) in groups of patients with different disorders must be included into general mental health care monitoring. Tracing the results of this evaluation, the most effective treatment methods must be reinforced and developed.

Our aim is to deliver appropriate good help to people who suffer from chronic mental disorders, and it is necessary to include psychological methods of treatment to the list. Moreover, we recommend priority to psychological help in cases of psychological crises, and we describe the standards of its delivery.

Investigations have shown that patients with the most severe conditions do not really receive integrated treatment, but only medical treatment, prescribed by psychiatrist. This medicalization of mental help does

not support an active participation of mentally disordered persons in the process of recovery. Thus, a significant number of persons suffering from severe mental disorders will be hospitalized repeatedly, sometimes several times a year. This group of patients with the highest request for resources must be separately analysed, extra attention is needed for managing their health and well-being. Methods of help and care being acknowledged worldwide must be delivered, e.g. active community care.

**Ramune Mazaliauskiene: One last question: how can specialists be influenced to deliver this kind of help-oriented activities in response to patients and their relatives?**

**Egle Sumskiene:** Change is necessary in the atmosphere of the treatment institutions. Foremost, there has to be a respectful attitude towards the patient with his or her needs and individual situation. System changes at the political level are also necessary. Persons who are look backward in beliefs and their working methods have to be excluded from this process. It would be useful to strengthen the critical autonomy and independent decision-making process of mental health care workers as they take the necessary steps. ■

# Changes in psychiatry

## Ottar Gudmundsson interviews three psychiatrists approaching their retirement

**Psychiatry has changed extensively over the last decades. New diagnosis and new medication have appeared and the debate on modern psychiatry has changed. Three experienced psychiatrists with decades of experience in their fields met recently for a brief conversation about this development.**

In the eighties, psychiatrists Högni Óskarsson, Tómas Zoega and Halldóra Ólafsdóttir, returned to Iceland after specialist studies in the United States. All of them have worked at the Psychiatric Ward of the National Hospital (Landspítali) and also engaged in private practice. All three have been active in psychiatrists' professional affairs and the struggle for the rights of their profession, as well as participating in various scientific work at the same time they are serving their patients.

### **What has changed?**

**Dr. Zoega:** The group of patients has changed. When I returned to Iceland it was simpler. Patients with more than one severe diagnosis are becoming increasingly common. Various diagnoses have materialized – developmental challenges, Asperger, ADHD, and other syndromes. When I returned from my studies the borderline concept was getting rooted, with much over-diagnosis. Today, most patients are addicts of some sort, which confuses the symptoms and makes treatment difficult. Major changes have occurred regarding the administration of medication. The SSRI drugs pushed out the old triangle drugs. The neuroleptic drugs have changed and developed. The side effects are less and more controllable except for obesity, which is a serious consequence of such medication.

**Dr. Óskarsson:** I do not fully agree with this. I find that unremarkably little has changed with respect of treatment. There is only a slight difference in the medication treatment – the effect is not greater, yet the side effects are somewhat less. The brain is an unbelievable phenomenon and considerably more complex than the heart, for example, which we have managed to map in detail. Much hope was attached to genetics – hopes that have failed. The same applies to genetics as to astrophysics – namely the more you learn, the less

you know. We always anticipate major breakthroughs and revelations, yet we are still waiting. Ketamine for depression was to be one of these revolutionary treatments, however, it turned out to be nothing. In the interim, we took hesitant steps. These factors are perhaps the most disappointing ones in the mindset of a man up in his years – that progress is not greater.

**Dr. Zoega:** Our professional environment has changed. The number of hospital beds has been reduced and the length of stay has greatly decreased, from 17-18 days to less than 10 days. This means more intensity and speed, which may be hazardous in some respects. People with long-term illness are no longer in the hospital – they are at community residences for disabled persons. Rehabilitation, which was a stronghold, has deteriorated to a great extent. Actually, the treatment never ends.

### **Have the goals of psychiatry changed?**

**Dr. Óskarsson:** The goal of modern psychiatry has been to adjust people to society. Various non-governmental organizations (NGOs) have materialized in recent times, assisting in this adaptation, for example the ADHA organization, Hugarafll, and the anorexia organization, to name a few. The dialogue becomes more open, which in turn lessens prejudice. In the psychiatry system, these NGOs often oppose the official system. This is not the case, for example, among cardiac patients, who usually work with, not against the hospital. This often means that patients turn negative towards treatment, particularly towards the medication used. Another factor that has changed is that we now know more about the groups at risk in our society and we are aware of the consequences of trauma and long-term stress, not the least during the adolescent years. Our knowledge about how environmental factors affect





Högni Óskarsson, Halldóra Ólafsdóttir and Tómas Zoega

mental disorders has increased much. A good example of this is PTSD and the psychological consequences of violence and other kinds of trauma.

**Dr. Ólafsdóttir:** This is also my experience. The debate on sexual abuse against children has become more open as a result of increased knowledge and less concealment. Every day we address serious consequences of abuse, for example long-term post-trauma stress, depression, and various physically stress-related illnesses, for example chronic pain. Additionally, we see a revolution regarding our knowledge about diagnosis and/or treatment in certain defined areas, for example eating disorders, borderline, post-traumatic stress, ADHD, various autism levels, and the initial stages of psychosis.

**Dr. Zoega:** The academic field of psychiatry did not sufficiently link these factors. Freud did so initially, but he then he moved away from it. As Dr. Ólafsdóttir states, the knowledge about the impact of various environmental factors on mental illness is extensive and increasing. It is alarming that many women committed

at psychiatric wards are victims of violence. Sexual violence suffered by women has major and serious consequences.

#### **What about diagnosis?**

**Dr. Óskarsson:** Diagnostics has increased, alongside with increased medicalization.

**Dr. Ólafsdóttir:** The diagnosis has become more detailed and purposeful, yet also more time-consuming. We must never forget, however, that the goal of diagnosis is to facilitate better treatment. Irrespective of diagnosis, I am by far most concerned about increased anxiety and depression among young people. All kinds of social changes have occurred and we do not know where such changes will lead us, for example changes such as increased use of social media and Facebook, and new criteria regarding one's own values. People literally compete over the number of likes they receive on their websites. This frequently generates stress and lack of self-esteem.

**Dr. Zoega:** The computer revolution has created a new group of computer-game addicts who spend a large portion of their time awake in front of the computer screen. This requires more examination.

**Dr. Óskarsson:** People's general awareness is considerably higher than before as a result of this flow of information in society, which in turn results in self-diagnosis of various illnesses. The quality of such information differs much, and it is frequently far from any truth or reality.

#### **Future of psychiatry?**

**Dr. Ólafsdóttir:** Specialization has increased to a great extent. Expert teams address special illnesses, and the results of treatment have improved in certain areas. However, psychiatrists sufficiently urged to engage in scientific work are largely absent, and there are few facilities for this purpose – for example at the National Hospital or in international collaboration. Icelandic psychiatry is behind some other medical disciplines in this respect.

**Dr. Zoega:** My opinion is that psychiatrists have given in too much with regard to management. Psychiatrists should head the psychiatric wards. Instead, we compete with well-educated personnel in other scientific disciplines.

**Dr. Ólafsdóttir:** Psychiatrists certainly hold a special position compared with other health disciplines, not only because of the medical background but also because of their very long education and training.

**Dr. Zoega:** Psychiatry should be an inseparable part of advanced medical studies. Using the methods of medicine is essential, not least for assessing the results of the various treatments.

#### **Considering the your vast knowledge in your field of expertise, would you study psychiatry if you were to choose today?**

**Dr. Ólafsdóttir:** I believe I would study psychiatry. This discipline is very varied and there are always unexpected elements. Of course, interacting over long periods of time with people who do not feel good in their soul, can be exhausting.

**Dr. Óskarsson:** An American study has revealed that 30% of psychiatrists would not have studied this field of medicine if they had known what the future had in store for them.

#### **What has the future in store?**

**Dr. Zoega:** There will be major progress over the next decades, in fact to such an extent that we can hardly imagine it. The brain is not directly accessible for research, however, but improved technology and knowledge will certainly make the future promising.

**Dr. Óskarsson:** Surely, we will soon see some progress in brain research. And hopefully, there will be more progress in genetics.

**Dr. Ólafsdóttir:** I hope we will acquire biological methods for supporting diagnosis in certain areas and make treatment more purposeful. I believe we will see this happen over the next few years. Additionally, there is very interesting research ahead into the interaction between environmental factors and psychiatric genetic heredity. ■

# Interview with Óttar Guðmundsson

Marianne Kastrup

## **Why did you decide to become so involved in the public debate?**

I would describe it as a development that has grown over the past 30 years. I started writing a column in a weekly magazine about food and cooking, then I did interviews and subsequently I published some books. I then began writing a regular column in the form of an informal article about my “alter ego” a cynical, hypochondriac, helpless doctor, who was very clumsy. This series was not critical and gave rise to little public debate, but at a certain point the editor of the paper felt that the column had outlived itself and I stopped writing it around 1994.

Instead I published some books on dying, alcohol and alcoholism, as well as on the history of Icelandic psychiatry – but these books neither became the subject of a public debate, nor were they written in a critical manner.

I started again around 2010 to send contributions to papers. Some three years ago I started my current newspaper column, and a Pandora’s box, so to speak, opened. I write about topics related to society in general. I write frequently about modern upbringing of children, critical comments about how society has become overprotective, situations that I find amusing or controversial, and I make an effort to be unpredictable.

## **Have you discussed your publishing activity with colleagues?**

Indeed, I had a supervisor who repeatedly told me that he felt the psychiatrist should not play a visible public role. Instead he should remain in the background and be a true listener, as this would be most beneficial for the patients. I debated with him – as I disagreed – but you may say that I also debated with myself. Later in my career I have often thought about my supervisor’s advice. My patients may have come to my office with too many preconceived ideas about me, based on my writings. And of course this may have some unwanted consequences for the therapeutic alliance and it might have influenced my patients’ trust.



## **Óttar Guðmundsson**

Óttar Guðmundsson is a specialist in both psychiatry and internal medicine and trained in Gothenburg and Reykjavik. He has worked in Sweden and in Germany. Today he works in Reykjavik, partly in his own psychiatric practice, partly as a specialist at the University Hospital (Landspítalinn). He runs a regular column in the largest Icelandic newspaper, has written extensively in newspapers and weekly magazine for many years and has published a number of books – among other things on the Icelandic sagas.





Óttar Guðmundsson and Egill Skalla-Grímsson

**Do you see any negative consequences of your public image and writings?**

Yes, and over the years negative consequences have become more obvious and unpleasant. Probably my writing is looked upon in the same way before, but the readers do not express a public opinion. With the emergence of the social media, many who previously kept quiet now write very harsh, often vulgar and nasty comments. People are very opinionated and often comment without reflection. Thus, consequences have in that way become more negative. Having said that, I also receive many positive comments.

**Do you find that the prize is too high?**

I think that the consequences are more unpleasant for my wife and children in facing remarks such as I am senile, old, an imbecile, and so on. Iceland is a small country and it can be tiresome for them to be confronted with hurtful comments about my person. You can find videos on Youtube about me with a radio program making fun of me, just to give an example.

From a personal point of view, these things do not stop me, even though I do not enjoy being the focus of offensive TV or radio spots – even if you realize that they are soon forgotten.

**So you will continue?**

I have no intention to stop. I find it fun to write these short comments and I think it is ok to be a public figure. It supports my own narcissism. I have also gained an insight in the work of journalists – for the better and worse – through my activities.

After all, I think we as psychiatrists have an obligation to observe and share things we find are important, and we should not remain invisible. ■



# Light in the habitat is a major driver of behaviour

Timo Partonen

The Sun is not only the dominant object in the sky during the day, but it is the source of virtually all light and heat that fuels life on the globe. A little more than 50 years ago, medical doctors in Europe and North America were using sunlight to treat diseases on a routine basis, and a number of hospitals were built for sunlight treatment. The natural daylight is thought to improve mental wellbeing, whereas right-timed exposures to artificial light can be beneficial as well, as far as they are not delivered in the form of light pollution. Light pollution refers to such artificial lighting, either indoors or outdoors, that does not produce clear contrasts between light and darkness. There is a decreasing strength of time-givers at a societal level, due to not only spending more daytime work indoors and less time outdoors during the day, but also receiving more light pollution during the night.

Compared to the prehistoric people who lived most of the time in the nature, the modern citizens spend 80% of their time indoors such as houses, schools, offices, malls, and public transportations. Seasonal changes in mood and behaviour are common in a general population and they are relevant to public health. In Finland, there are some 1,226,000 persons (39% of the whole population aged 30 and above) who routinely suffer from seasonal changes in mood and behaviour.

Not only the seasonal changes in mood and behaviour, but also poor illumination levels at home or at a working place, may have a negative effect on mental wellbeing. Concerning the health-related quality of life, the negative effect of poor indoor illumination is equal to but is counteracting the positive effect gained



Timo Partonen, MD, Research professor, Adjunct professor of psychiatry

with regular fitness exercise. The intensity of seasonal changes in energy levels, mood, and social activity, will negatively effect the health-related quality of life. This effect was second only to the intensity of depressive symptoms, and greater than that of age.

On the one hand, greater social activities, more activities outdoors, and living together, are directly associated with better mental wellbeing. On the other hand, greater seasonal changes and poor luminance indoors are significantly associated with worse mental ill-being. The intensity of seasonal changes in mood and behaviour has a negative effect on mental well-being. In other words, this effect is greater than that of sex, age, education, out-door or social activities.

There is also a seasonal variation in deaths from suicide as seen in global mortality statistics, spring and early summer being the most dangerous seasons. A peak in deaths from suicide is preceded by a peak in suicide attempts a month earlier. These two peaks, being similar and more robust the farther away from the equator the country is located, have been explained by socio-demographic and socio-economic factors. However, since this seasonal pattern has existed for decades, if not centuries, biological factors are more likely. Suicide is usually a long process, whereas the timing of death appears to be far from random.

Major depressive episodes are known to contribute substantially to suicide. Misalignment of physiological rhythms, e.g. the circadian rhythm of core body temperature not being in pace with the sleep-wake cycle, associates with mood disorders. An hypothesis is that this misalignment may increase among the depressed and predispose them to suicidal behaviours during the spring.

Another challenge of the master clock, being located in the anterior hypothalamus and receiving time cues through the eyes, might be the seasonal mismatch during the spring. This mismatch emerges from conflicting signals to the master clock. The often-seen abrupt “see-sawing” or roller-coaster-like temperature fluctuation in the spring will put a strain on the thermoregulatory mechanisms, especially in the depressed. An hypothesis is that the increasing thermal stress on warm days after cold spring nights will over-activate brown adipose tissue, producing extra heat and disturbing thermoregulation in the depressed. This disturbance has been suggested to trigger anxiety and psychomotor agitation by changing activity in brain areas receiving projections from brown adipose tissue. In this way, feelings of depression may deepen and the risk of suicide increase.

Once brown adipose tissue is metabolically active it is more resistant to getting quiescent, and then it will become more subjected to defects in heat tolerance. There is a transient increase in the prevalence and volume of brown adipose tissue around the time of puberty – the incidence of cold-stimulated brown adipose tissue activity is as high as 100% in young adults. This might be just a coincidence, or the activity of brown adipose tissue may contribute to the emergence of mood disorders and the increase in suicide mortality around the time of puberty. This might explain the timing of a deepening of depressive episodes and a peak of deaths from suicide after the winter months during late spring and early summer.

Rest-activity cycles during the day and sleep stages at night are controlled by the master clock, but they are frequently disturbed in depression. In patients suffering from major depressive disorders with a seasonal pattern, the rest-activity cycles are elastic, as they delay too much sometime, and sometime they will advance more than usual. In major depressive disorder with melancholic features, the circadian rhythm of core body temperature tends to advance abnormally, and the rapid-eye-movement sleep stages emerge too early.

The master clock in humans entrains to the sunlight in the morning hours and tracks the daily changes in rise and set times of the sun. Based on this information, the variation in the length of day is anticipated. The timing of light exposure is relevant to resetting and entrainment of the intrinsic rhythms, it guides behaviour, and influences the course of mood disorders. Thus, the key to the suicide mortality peaks may lie in the light-darkness transitions, which give the master clock a signal to accelerate or decelerate. Further studies are needed to demonstrate whether brown adipose tissue is abnormally active or activated in the depressed, and if it is, whether it contributes to mood and behaviour.

The preference to schedule the timing of daily activities to morning or evening hours forms a continuum and is called a chronotype, with the anchorage poles of “early birds” and “night owls”. During puberty, some adolescents gravitate toward preferring being a “night owl” and they remain so after the puberty. Health hazards that do differ between the chronotypes, such as depression and winter blues, are all more common among “night owls” compared with “early birds”. Thus, it will be relevant to find out the key mechanisms that favour this inequality of the chronotypes, identifying persons who remain at clinically meaningful risk, and providing them with a protective intervention early enough. ■

# Nordic Congress of Psychiatry

**The 32<sup>nd</sup> Nordic Congress of Psychiatry will be held 13-16 June 2018 at Reykjavík's new concert and conference center, Harpa.**

The theme/title of the congress is Shaping the future. Previous congresses held in Iceland have been quite successful with attendees expressing their satisfaction about the arrangements.

We approached two psychiatrists, Halldóra Jónsdóttir and Magnús Haraldsson, asking them about the congress in 2018. Both hold seats on the preparatory committee.

## **What are the main issues of the congress?**

We emphasize mainstream psychiatry and clinical work, as well as the daily problems faced by everyone at the clinic, the ward, and in our daily lives. We will also discuss new trends and tasks of our profession.

## **What are the main tasks?**

The number of young people with serious mental disorders has increased dramatically. We will discuss this in particular. Various new kinds of treatment will be addressed, for example, telemedicine or distance medicine, as well as transgender issues. Genetics and genetic research will be discussed, as these are issues that regularly materialize in Iceland.

## **The arrangement of the congress?**

We will have seven plenary speakers, one from each of the Nordic countries, and two from Great Britain. The website of the congress, [www.ncp2018](http://www.ncp2018), contains detailed information about the speakers. There will also be sessions/seminars, based on issues that people send to us. We appreciate and encourage people to send information to us about innovative and new research in order to make the scientific value of the congress as high as possible.

## **Do you offer anything special?**

Icelandic psychiatrists are quite leading in various areas. We have succeeded in developing a very effective parent-infant clinic, where we receive mother and child together at the ward on a need basis. We will introduce community psychiatry as it is practiced in Iceland. We have patients' shortest length of time in psychiatric wards and the smallest number of beds.



**Halldóra and Magnus**

We have responded to this situation by developing a psychiatric community team caring for patients who cannot be admitted at a ward, yet are in much need of treatment.

## **Anything else?**

Suicide will be discussed, as this is a constant problem for all psychiatrists. We will also address various sexual problems, transgender issues, etc.

## **What about the social life?**

The opening ceremony will be held at the Reykjavík Art Museum and the gala dinner will be enjoyed at our magnificent concert and conference hall, Harpa. We will hear music and well-known entertainers. A special patron of the congress will be Mrs. Elizabeth Reid, the wife of the president of Iceland.

## **In conclusion...?**

Iceland has become one of the most popular must-see countries in the world. Iceland's nature is unique and touches you to the core. The sun will never set during the congress days and we sincerely hope that the midnight sun and a highly interesting scientific congress will attract many attendees to join us. ■





# Psychiatry - Shaping the future

**32<sup>nd</sup> Nordic Congress of Psychiatry  
June 13-16<sup>th</sup> 2018, Reykjavik Iceland**



# Interview with Dinesh Bhugra, president of the WPA 2014–2017

Hans-Peter Mofors

With only two more hours to go of this presidential term, I got to share one of them with Dinesh Bhugra in a meeting room hall at the Messe Süd in Berlin. The big conference arena was soon to shut down, visited by thousands of psychiatrists from all over the world at this latest WPA meeting.

**Dinesh looks remarkably relaxed.** Despite numerous appearances during the conference, he shows no signs of exhaustion. And after three hectic presidential years, he has absolutely no plans on winding down. Actually, in half a year from now he is to enter a new big task, as the president of the British Medical Association. Before then, he plans to finish no less than four books with focus on cultural psychiatry, mental health, and migration health.

Why is there a need for an international psychiatric association?, I ask. It is clear that this is a subject that Dinesh is burning about. – The quality of the psychiatric care is very unequal between different countries, says Dinesh. And maybe, even more so, the rights of people with mental health issues.

– Only an international organization will catch the global picture. Therefore, big organizations are indeed needed.

– During my period in the WPA we carried out a survey to 193 countries. It turned out that in no less than 40 percent of the countries of the world, people with mental disabilities do not have the same rights as



## Dinesh Bhugra

Emeritus Professor of Mental Health and Cultural Diversity at the Institute of Psychiatry, Psychology and Neuroscience at King's College London. Past President of the Royal College of Psychiatrists. Past President of the World Psychiatric Association for a three year term, 2014–2017.

others. And compared with other individuals, they have lesser rights to inherit, to vote, to marry, or to write a will.

In order to make a change in these matters, WPA has taken initiatives addressing governments in all

countries with a bill of rights for people with mental illness. This work is carried out through the national psychiatric organizations.

According to Dinesh Bhugra, all governments need to establish policies about mental health. There needs to be a proper funding for both physical and somatic health. Before major decisions are carried out, analyses are needed as to how they will impact on people with mental health problems. At last, the work with deinstitutionalization needs to continue. There are still countries in which patients are treated in big institutions with no rights.

Again, by sharing the good practices, we can contribute to equalizing the level of treatment. It is also all too clear that the quality of psychiatric care varies much between different nations. There is an immense need to share good practice and education. Dinesh says that he believes in the idea of raising quality by way of these methods.

Under the leadership of Dinesh Bhugra, the WPA has also worked with LGBT questions. Out of seven major task forces, one was about LGBT. – There is still much work to be done in this field, say Dinesh. For instance in Indonesia, homosexuality is considered a mental problem. Old treatment, such as conversion therapy is still around.

### **The butterfly**

One of Dinesh Bhugra's legacies will no doubt be the blue butterfly. WPA looked for a symbol for the campaign "Social justice for people with mental illness", which was linked to the bill of rights. Sixty countries have now signed.

Having abandoned the idea of another "ribbon", the butterfly symbol appeared to Dinesh during a trip to Costa Rica. This blue butterfly is in Latin named *Morpho menelaus*. The butterfly itself represents psyche, soul, and freedom. The blue color is known for joy and wish-fulfillment. ■



### **About WPA**

The World Psychiatric Association (WPA) is an association of national psychiatric societies with the aim to increase knowledge and skills necessary for work in the field of mental health and in the care for the mentally ill. The number of its member societies is at present 138, spanning 118 different countries and representing more than 200,000 psychiatrists.

The WPA organizes the World Congress of Psychiatry every three years. It also organizes international and regional congresses and meetings, and thematic conferences. It has 72 scientific sections, aimed at disseminating information and promoting collaborative work in specific domains of psychiatry. It has produced several educational programmes and a series of books. It has developed ethical guidelines for psychiatric practice, including the Madrid Declaration (1996).

# Report from a leadership and professional skills course

Magdalena Flaga-Łuczkiewicz, MD, psychiatrist, Dialogue Therapy Centre Clinic, Warsaw, Poland.

Natalija Berzina-Novikova, MD, trainee in psychiatry, Riga Psychiatry and Addiction Centre, Riga Stradiņš University, Latvia.

Amélie Kjellstenius, MD, trainee in child and adolescent psychiatry, Queen Silvia Children's Hospital, Sahlgrenska University Hospital, Gothenburg, Sweden.

Aistė Lengvenytė, MD, trainee in psychiatry, Clinic of Psychiatry, Faculty of Medicine, Vilnius University, Lithuania.

Thanks to Dr Renata Žakauskė and her team from the Lithuanian Psychiatric Association – the WPA Inter Zonal Congress in Vilnius last May was preluded by a three-day long Leadership and Professional skills course for Early Career psychiatrists. The course was funded by the Nordic Council of Ministers' Office in Lithuania. Under the leadership of Professor Norman Sartorius and Professor Ida Hageman, sixteen young psychiatrists from nine European countries – Latvia, Lithuania, Belarus, Poland, Denmark, Sweden, Norway, Finland, and Estonia – came together to practice key skills for a successful career in psychiatry. Here is a short report on the course, received directly from the participants.

The course was intensive from beginning to end, and every point of the programme reinforced the idea that you learn best through experience. Professors Sartorius and Hageman encouraged us to be active. We practised how to make a speech to get elected, how to introduce someone successfully, and how to prepare and present a mental health project in order to gain funding.

Ahead of the course we were asked to prepare an oral presentation and a poster. During the course everyone had the opportunity to present their work and to give and receive feedback on the speaking style, slide design, and overall impression. We learnt how to handle difficult questions from the audience and gained new insights into the importance of non-verbal communication.

Role-play was used in another practical exercise on how to lead a productive meeting. One of us was chairman, not knowing that roles had been given to all meeting participants, most of which were not collaborative. What an emotionally challenging exercise it was! Both participants and observers were fully engaged.

There were also educational sessions on how to write a good scientific paper – this part was lead by the editor of Acta Psychiatrica Scandinavia, Professor Ida Hageman. We also revised our professional CVs

and prepared motivation letters for our dream jobs and reports from scientific events. In a round table discussion with Professor Eugenijus Laurinas we talked about some controversial topics in modern psychiatry. All coffee breaks and lunches during the course as well as the festive dinner were occasions to talk and get inspired, exchange ideas and opinions, get to know each other better and plan for further collective work.

As participants of this great event, we are very thankful for gained knowledge and experience and we hope to repay by pushing psychiatry a little bit further in the future. ■

**Professor Norman Sartorius** has lead professional skills courses for young psychiatrists since 1994, in collaboration with other experts in the field. Courses run annually in Berlin and Basel and are also given as pre-events at international conferences in different parts of the world. A small group of participants are chosen to take part in each edition to allow active participation.





# Highlights from the Nordic Journal of Psychiatry

Martin Balslev Jørgensen

## **Increase in depression among young girls**

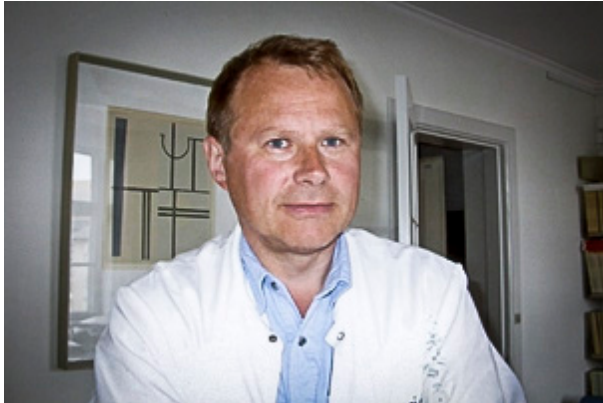
In this Danish Nationwide cohort study on data from 2000–2013 incidence rates as well as 1-year prevalence rates were calculated. The incidence and 1-year prevalence rates of depression diagnoses increased during 2000–2013. The women/men rates were 2.0 for both 1-year prevalence of depression diagnoses and antidepressant use. For adolescent girls, the absolute increase was 3 per 1000 for depression diagnoses and 8 per 1000 for first use of antidepressants, compared to boys who had an increase of 1.1 and 3 per 1000, respectively. Before puberty, boys and girls had almost the same incidence rates of both depression diagnoses and antidepressant use throughout the period. After puberty, girls had significantly higher incidence rates than boys, and experienced during the study period a steeper increase than boys. According to age, the girls/boys incidence rate ratio of a depression diagnosis increased from 0.8 in the 10–11 year age group to 2.7 at age 12–19 years and hereafter decreased with increasing age to 1.5 at age 45–49. It is concluded that depression diagnosed and first use of antidepressants increased more for girls of 12–19 years than for boys during 2000–2013, and the incidences were similar for girls and boys before puberty, but higher after puberty for girls.

**Skovlund CW, Kessing LV, Mørch LS, Lidegaard Ø.** Increase in depression diagnoses and prescribed antidepressants among young girls. A national cohort study 2000–2013 *Nordic Journal of Psychiatry*. Jul 2017, Vol. 71:5, p378–385.

## **Adolescent suicide attempts and concurrent adversities among Sami and non-Sami.**

The authors investigated prevalence, additive effects of adversities, family and peer relations, gender, divorce and poverty, and ethnic differences between Sami and non-Sami youth in an adolescent community population of 15–16 years of age. Youth with and without self-reports of attempted suicide the last year were compared on 12 concurrent adversities, on scales assessing family and peer functioning, and on sociodemographic variables. The prevalence of attempted suicide was 5.3%, and more girls (8.8%) than boys (1.8%). All 12 adversities were strongly related to suicide attempts. The suicide attempters reported two and a half times as many adversities as non-attempters. Among boys, the strongest risk factors were suicide among friends (OR=9.4), and suicide in the family or in the neighborhood (OR=4.8). Among girls, sexual abuse (OR=5.2) and parent mental problems (OR=4.6) were strongest related to SA. Suicide attempts reported more divorce and poverty, more conflicts with parents, and less family support and involvement. Totally, Sami youth reported more SA and more concurrent adversities than non-Sami peers. It is concluded that adolescent suicide attempts are heavily burdened with concurrent adversities. Clinicians should be aware of gender differences in risk factors, and should ask about abuse and suicide or attempts among relatives and peers.

**Reigstad B, Kvernmo S.** Concurrent adversities and suicide attempts among Sami and non-Sami adolescents: the Norwegian Arctic Adolescent Study (NAAHS). *Nordic Journal of Psychiatry*. Aug 2017, Vol. 71:6, p425–432.



**Martin Balslev Jørgensen**  
Professor dr.med., Editor-in-chief

### **Lessons from early psychedelic therapy in Denmark**

New research has suggested the clinical use of lysergic acid diethylamide (LSD) and psilocybin in selected patient populations. However, concerns about the clinical use of LSD is advanced through a Danish follow-up study that assessed 151 LSD-treated psychiatric patients approximately 25 years after their treatment in the 1960s. The present study was to give a retrospective account of the short-term outcome of LSD treatment in these 151 Danish psychiatric patients. The author reviewed this LSD case material in the Danish State Archives consisting of medical case records of 151 LSD-treated patients, who complained and received economic compensation with the LSD Damages Law. LSD was used to treat a wide spectrum of mental disorders. Independent of diagnoses, 52 patients improved, and 48 patients worsened acutely with the LSD treatment. In a subgroup of 82 neurotic patients, the LSD dose-index (number of treatments multiplied by the maximal LSD dose) indicated the risk of acute worsening. In another subgroup of 19 patients with obsessive-compulsive neurosis, five patients later underwent psychosurgery. A small subgroup of 12 patients was treated with psilocybin. The long-term outcome was poor in most of the patients. It is concluded that despite the significant limitations to a retrospective design, this database warrants caution in mental health patients. The use of LSD and psilocybin in mental health patients may be associated with serious short- and long-term side effects. Until further trials with rigorous designs have cleared these drugs of their potential harms, their clinical utility in these groups of patients has not been fully clarified.

**Larsen JK.** LSD treatment in Scandinavia: emphasizing indications and short-term treatment outcomes of 151 patients in Denmark. *Nordic Journal of Psychiatry*. 2017, Vol. 71 Issue 7, p489-495.

*And don't miss the invited editorial on this subject:*

Erritzoe D, Richards WA. Lessons to be learned from early psychedelic therapy in Denmark. *Nordic Journal of Psychiatry*. 2017, Vol. 71:7, p487-488.

### **Sensory modulation in inpatient care can reduce seclusion and restraint**

Sensory-based interventions promote adaptive regulation of arousal and emotion. Sensory Modulation (SM) is an approach that may reduce rates of seclusion and restraint in mental healthcare. The present study included two similar psychiatric units where one unit implemented SM and one unit served as the control group. In the very beginning of the study, a staff-training program in the use of SM including assessment tools and intervention strategies was established. Data on restraint and forced medicine were sampled post the course of the year of implementation and compared with the control group. The use of belts decreased with 38% compared to the control group. The use of forced medication decreased with 46% compared to the control group. It is concluded that implementing a SM approach in mental healthcare facilities has a significant reducing effect on restraint and seclusion. As a part of the implementation, staff training and education in SM are crucial.

**Andersen C, Kolmos A, Andersen K, Sippel V, Stenager E.** Applying sensory modulation to mental health inpatient care to reduce seclusion and restraint: A case control study. *Nordic Journal of Psychiatry*. 2017, Vol. 71:7, p525-528.