THE NORDIC PSYCHIATRIST

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Crossing Borders

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Crossing Borders,

Borders define both the known and the unknown. Standing on the inside, one is safe and in control. Crossing over to the other side brings with it uncertainty, but with both good and bad possibilities. Borders are physical as well as ideological, created by us as a means to protect our integrity. Both animals and humans have a need to mark their space, to draw boundaries.

We often draw boundaries to mark what is acceptable and what is not. Some individuals are more sensitive when these are crossed, and others are not. What constitutes a crossing also depends on the context and the people involved. Some are better at respecting other's boundaries. As psychiatrists, we often have to deal with interpersonal issues related to this topic. As a doctor, we have to deal with the question of borders relating to the patient. Is it suitable to be friends with a patient on Facebook?

Crossing borders can also be a positive undertaking. Opening up for new possibilities and leaving one's comfort zone to explore the unknown may bring development and progress. Working as a psychiatrist in another country means literally to cross borders in order to learn and gain new experiences, and can be very rewarding.

We have chosen the title "Crossing Borders" as the theme for this issue of the Nordic Psychiatrist, and, as always, colleagues have contributed a number of articles addressing this theme — always with a psychiatric perspective.

We also report about current events in the field of psychiatry in our countries along with a report from the very successful psychiatry conference last summer on Iceland. And as always, you will find a summary of the most important articles from the last issues of Nordic Journal of Psychiatry.

Happy reading!

Hans-Peter Mofors, Editor

Is fusion law the future?

Ulrik Fredrik Malt

Ulrik Fredrik Malt
Emeritus Professor of Psychiatry and Psychosomatic Medicine, Institute of Clinical Medicine, Faculty of Medicine, University of Oslo, Norway.

Persons with severe mental disorders are potentially liable to detention in psychiatric hospitals and quite often subject to coercive treatment with antipsychotics. Why? Because they are assessed as presenting a *risk* of harm to others (1). However, few persons with severe mental disorders do commit criminal offences or harm others. Most harm to others or other criminal offences are conducted by persons without any mental disorder. Even though this is hard facts, a person without mental disorder who is assessed as presenting a risk of harm to others is *not* subject to preventive detention and coercive treatment.

Furthermore, in most countries, the presence of a severe mental disorder (e.g. schizophrenia) is considered to imply lack of decision capacity without further inquiry. The person's beliefs and values are not considered even though the presence of a psychotic disorder does not imply that beliefs or values must reflect psychotic ideas. In contrast, persons suffering from a severe physical disorder, are considered to have decision capacity without restrictions, even if they are severely ill and refuse treatment with subsequent risk of severe health deterioration or even death.

These discrepancies in legislation are discrimination of the mentally ill and call for a fusion legislation (law). A fusion legislation is the removal of the interface between mental health legislation and mental capacity legislation. Patients with mental and physical disorders are treated equally under the law. Fusion legislation also broaden the scope of legislation in diagnostic terms, to include for example personality disorders, attention-deficit hyperactivity disorder, neurodevelopmental disorders, and intellectual disability of any severity (2). The crucial point is not psychosis, but decision capacity. Fusion legislation is also more compliant with the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

In theory, fusion law may increase the patients' autonomy at the expense of beneficence and perhaps risk of harms to the public. Difficulties to assess decision capacity in some cases of psychotic disorders may represent another problem. But several measures may counteract potential negative effects of a fusion legislation (2). This includes supportive decision- making measures, second opinions and mental capacity advocacy.

In 2016 Northern Ireland became the first country in the world to enact a single capacity-based legal framework to legislate for the involuntary treatment of all in society, including the mentally ill, labeled The Mental Capacity Act- MCA (2). This implies placing the treatment of mental illness within the same legislative framework as physical illnesses, labelled fusion law or fusion legislation. In Norway, the first step towards a fusion law was taken in 2017. The presence or absence of decision capacity, not psychosis per se, is now considered to be the first crucial step to decide if coercive treatment is allowed. The next step, to have the same legislation for all persons, disregarding the presence or absence mental disorders, is supported by the Norwegian psychiatric association. Discrimination of the mentally ill should stop. Fusion law is the future. ■

1. Szmukler G. Has the mental health act had its day? BMJ 2017; 359: j5248 doi: 10.1136/bmj.j5248
2. Campbell P, Rix K. Fusion legislation and forensic psychiatry: the criminal justice provisions of the Mental Capacity Act (Northern Ireland) 2016. Br J Psych Advances 2018; 24: 195-203.

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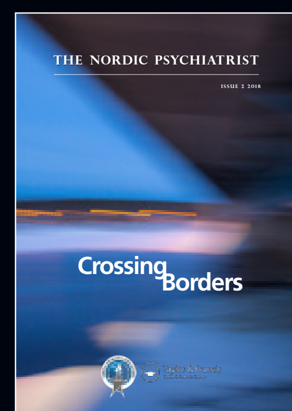

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Crossing borders – examples from clinical practice

Marianne Kastrup

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MD, Ph.D., former Head National Center Transcultural Psychiatry, Denmark.
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The editorial group has asked colleagues to provide examples from their daily clinical work, where they have felt that their personal boundaries were crossed or that they crossed those of the patient. There are many communalities across the borders of the Nordic/Baltic countries in the experiences of doctors. We have chosen to bring the examples in an anonymous form and we would like to thank all contributors to share their personal reflections and experiences.

Sexual aspects

Several colleagues mentioned situations of a sexual nature. Psychiatric patients come to us expecting trust, we meet them in vulnerable situations and must set clear boundaries and constantly remind ourselves hereof. But we may also experience sexual advances from our patients:

"A male patient around 60 years came to my clinic years ago with depressive symptoms but revealed during the conversation that he had been accused by a female colleague for sexual harassment. He had threatened the colleague with going to court for libel and she then withdrew the allegation. After the consultation the patient gave me – a female psychiatrist - a hug and kissed my cheek. I did not comment this behaviour subsequently as this was not the focus of his treatment, but when he subsequently came for treatment I kept him at arm's length. He crossed my boundaries and probably that of his colleague - without realizing it".

"In a psychiatric nursing home, I – a male psychiatrist - had a female patient suffering from a bipolar condition. She was aged 67 and frequently in a hypomanic state. When I saw her the first time she embraced me quite strongly - at that time she was in a neutral state, and every time I came the embrace was repeated. Subsequently she wanted to kiss my cheek. I told her to stop this practice, but she continued despite I again informed that I could not accept such behavior. I did my best to inform her in a polite way. Finally, when it did not help, I told her that if she did not stop she had to get another doctor – surprisingly that helped but she clearly overstepped my boundaries."

"I had a male patient who was deliberately making me feel unsure and uncomfortable by asking intimate questions and making speculations about my personal life and why have I moved to town. I was working as a GP at that time and was so confused that I didn't know how to stop his behaviour. Later, it was obvious that this man had narcissistic or even antisocial personality disorder."

Misunderstanding – when patients misunderstand the therapists

Showing empathy is part of our professional role but despite our efforts to show empathy we may be border crossing and be perceived as provocative. As pointed out by a female psychiatrist *"when I consider whether I have crossed boundaries I personally do not think that I have – but I may have without knowing it, and maybe some patients have dropped out from treatment as they have felt intimidated."*

As a therapist you run the risk of being misunderstood, and you may to your surprise be faced with a complaint. A female colleague told *"I had a patient in 10 years. She had a severely handicapped child who turned 18 while she was my patient. She spent a lot of time fighting the municipalities to get help to the child. On one occasion I asked her whether she felt the child was a burden which she admitted – and even looked relieved by my question. I tried at a point to reduce her medication, but she felt worse every time I tried. In the end I referred her to community psychiatry and years later I got a letter from her in which she was questioning whether I had ruined her life. She felt much better after community psychiatry had reduced her medication. She wrote that she felt pity for me that I could make myself ask such a question about her child. She must have experienced my remark as border crossing, but I do find that it was a very relevant comment even if I may have used a strong word".*

A similar experience is reported by another female colleague. She told that *"years ago I had a patient in therapy who was referred due to problems in her relationship with her boyfriend. In our first session I questioned whether she could consider leaving him. She got so angry that she left the room. I never saw her again and later she wrote a complaint about me."*

In another case the psychiatrist had her first consultation with a fragile woman and *"to my great surprise I received subsequently a written complaint that I had behaved hard without empathy and crossed her boundaries. I replied that I was very sorry, but it remained unclear to me how I had crossed her boundaries."*

Another colleague tried therapeutically to confront patients and used a very direct technique. Later she reflected whether *"my questions may have been crossing borders and been perceived as provocative by the patient. I used this approach to let the therapy move on, but it may not have worked. I could e.g. say" Now you have spent 5 min on not answering my question – is this typical for you?"*

But miscommunication may have positive consequences. *"I worked at the acute psychosis department and had a patient who was talking only about his "special shit" all the time, complaining about it, asking for help because of obstipation, etc. No drugs or other means seemed to have any effect. One day I was very tired because of enormous amount of work. I walked into department, and my patient was there. He started to talk about his "special shit" as usual, and I responded quite irritably "Oh, I am almost mad myself today, could you please, shut up?". The patient looked very seriously at me and responded with understanding in his voice: "OK, doc". I had a strange feeling that my patient was much more professional and more ethical in that situation, and I had a bad feeling of shame, as well. But to my great surprise the relationship with this patient improved, and his mental status became better after that."*

Therapists may also misunderstand their patients. *"One night I was on duty and was called to a woman who had recently had an abortion. We had a conversation about this and other things that mattered to her. Two hours later I was called to the same ward. She had been very violent and destroyed everything around her. She had to be restrained and I was wondering if I had misinterpreted her situation and crossed her boundaries without knowing it."*

Working with patients who have another mother tongue have special challenges. Several therapists may recognize the following: *"In some cases when I have used an interpreter –(mostly Arabic speaking men) the therapy has not progressed smoothly, and I have felt irritated, and this has probably been obvious. This is maybe not crossing borders, but it is indeed unprofessional. I have been thinking whether the unsuccessful therapy could be due to that I crossed some borders without knowing it."*

Another example documenting the risks when talking to patients of other nationalities. *"I was describing the expected effects of a new medicine to my patient. He was an English native speaker while I am not. I accidentally said the medicine will" put you to sleep" (i.e. "kill you") and realised my mistake immediately. This brought tears to my eyes although later this blunder was handled with great mutual humour".*

Social media, telephones and other contacts

Social media is taking up an increasing part of the world we live in. From an ethical perspective this issue has till now not received sufficient attention - where are the limits for our involvement – if any – with pa-

tients? Several colleagues had been faced with such issues. And what about providing patients with our telephone numbers? Some doctors find that natural, other say *"I always wonder what makes our patients or their relatives ask for our personal phones "just in case if…". And every time I see some of their disappointment when answering "no". And I try to explain, but still I always feel a bit guilty, though I know for sure that I don't have to be available for 24 hours"*.

Other kinds of border crossing?

We have considered the many kinds of borders and how to keep a professional distance. But reality is often much more complex, and the fine principles may be difficult to hold in practice.

"After my graduation from medical school, I became a doctor at a small fishing village in Iceland. This was a closed community and entering it was hard. In my capacity as the village doctor I soon discovered that not only was I among the high-society, as I also enjoyed all kinds of benefits. I never had to wait at the gas station and I was usually offered the front place at the kiosk queue or at the grocery store. Iceland's richest lobster grounds were located off the coast of this small village. The fishermen started sending to me exquisite lobster tails every now and then; turning my intern year into a year of lobster feasts.

I have frequently wondered whether I crossed all borders at the village this year. Was it appropriate for me to accept these gifts of food? Should I have allowed myself to be treated like some head-of-state at the grocery store and at mechanical workshop. This is a reality that many medical doctors in the rural districts experience where the doctor is an important component of the daily struggles at the village. Always something in return is a sentence referring to how he or she giving gifts always expects something in return. People assume that the doctor will show his appreciation for all such gifts by being extra helpful and kind. Gradually the doctor begins to feel indebted to the community which in turn has impact on his work and contribution. I felt as being released from bondage when I eventually left the village and embarked on a journey into the big world where I soon became one of the non-privileged masses!"

Many patients may have difficulty in understanding the unique nature of the therapeutic relationship. And how do we react to that. A colleague states *"A few times some of my patients started the talk by asking me how I feel. This is my usual question to them, so I felt quite strange hearing it from them. Though it is a normal question in "normal" life"*.

We may also experience quite different kinds of feeling our boundaries crossed by patient as this psychiatrist who writes *"I find it uncomfortable when patients enter my dreams at night. That's my private time and it feels like I'm working without having control over my free time. This happens rarely though"*.

Working conditions – another kind of border crossing

Interestingly some find that colleagues and employers also have difficulty in respecting boundaries and that this can be very problematic.

As a colleague stated *"I frequently think about situations where boundaries were crossed, but to me this has more often happened in relation to staff than to patients. I recall many situations where staff has crossed my boundaries."*

And what about our employers do they respect our boundaries? *"Our superior had inconsiderately decided to add some extra patients in my calendar without even discussing it with me. This meant losing the time that was reserved for paperwork."* ■

Nordic Congress of Psychiatry in the summer of 2018

Óttar Gudmundsson

The Nordic Congress of Psychiatry was held in Iceland during 13-16 June. The organisers of the congress wish to express their appreciation to all those who came to Iceland, contributing to making the congress a success. The weather was very favourable, small showers of drizzle rain, moderate winds and temperatures at 12–14° C. There was no snow during the congress days. While we enjoyed the freshness of the Icelandic summer, the whole of Europe was subject to high temperatures, in fact a heat wave, resulting in people literally fleeing the cities. The Flora dried up and brave fire-fighters fought forest fires started by the heat. The attendees at the Nordic Congress of Psychiatry monitored the situation back home, zipping up their warm coats and facing the Icelandic weather and rain. Many were concerned about returning home after having become used to the wonderful Icelandic summer climate.

The congress was as successful as could be. The selection of plenary lecturers was sophisticated. They came from various parts of the world, addressing a selection of topics. Some might be misunderstood as the case may be; however, attendees were generally happy about the lecturers. Those who had no understanding of the science at hand were clever enough not to talk about it.

The selection of lecture sessions was extensive, resulting in some attendees feeling apprehensive about what to choose. There were those who could not make up their minds about where to go and some were even seen roaming the lecture halls in an attempt not to lose out on anything. Some complained that the programs were too extensive. Then there were those who decided not to show up at any session and thus avoiding having to choose simply by doing something totally different.

The culinary delights and drinks were in abundance, both in terms of quality and quantity, but then again the dietary tendencies of today's people have become so complex due to all kinds of allergies, special requirements, and various diet or fat programs. Nevertheless, every effort was made to meet everybody's

Óttar Gudmundsson and Johanna Thórhallsdottir.

Picture below:
The executive committee - left to right: Kristinn Tómasson, Thorgunnur Arsælsdottir, Sigurdur Páll Pálsson, Nanna Briem, Halldóra Jónsdóttir, Magnús Haraldsson

needs, both those of minority and majority groups. The Master of Ceremony and various entertainers did all in their power at the gala dinner, held on the last night, to pinpoint Icelanders' superiority in all walks of life but fortunately did not reach the attendees too well as most of them were swirling around on the dance floor, happily enjoying the last few hours of a successful gathering.

The congress was held at Harpa, Iceland's most magnificent concert hall, and also in fact Iceland's most expensive hall at that. Harpa is one of the reasons for the bankruptcy of Iceland and Reykjavík in the wake of the economic collapse in 2008. Consideration was made way back then as to whether the building should remain half-finished in remembrance of the nation's optimism and financial illiteracy. However, the building was finished after loads of money had been poured into it. The Icelandic people have long since forgiven Harpa and have instead turned it into the centre of conference and music in Iceland.

The next congress will be held in Finland in 2021, and then again in Iceland in 2042. These congresses are the perfect venue for medical doctors and others to meet and enjoy the company and expertise of their colleagues and friends. ■

How to cross a border and go ahead, not being a victim

Some reflections on the positive and negative aspects of victimhood

Lars Weisæth

Professor emeritus Lars Weisæth at the University of Oslo has done research in the psychotraumatology field since the 1970s, in a string of scientists like Leo Eitinger and Arne Sund, the world's first professor in this field. He has recently co-edited the 2nd edition of the international Textbook of Disaster Psychiatry at Cambridge University Press. We asked him to give his views on clinical aspects of victimhood.

The term "victim" is strongly associated with being innocent and without responsibility for some harmful event. This is a valuable attribution for individuals who have been abused in one way or another and often struggles with shame, guilt, and self-reproaches.

However, with such positive connotations, it comes as no surprise that victimhood has been claimed as part of a strategy in order to escape responsibility. At the national level, the Austrian attempt, partly successful, in claiming to be "the first victim of Nazi aggression", comes to mind, the Hungarian rewriting of their WWII history, as well.

In contrast, West Germany's honest and almost ruthless self-examination blocked access to war victim status for the many thousand German women exposed to rape, particularly by the advancing Soviet army. When we worked in a WHO team in post-war Kuwait, their rape victims likewise were denied war victim status; to protect the women from social stigmatisation was stated to be the reason. In both these cases it is likely that war victim status would have helped the abused women in many ways.

Citizens exposed to terror attacks, such as the employees in the ministries in Oslo and the youths at Utøya on July 22, 2011, clearly are innocent victims of criminal violence. However, political violence differs from other criminal violence in that it is not only an attack on innocent human beings. It is also an attack on their nation. Thereby they become participants, without having volunteered for it, in an important fight for basic democratic values. The identity and role of being a participant provide strong meaning, and psychosocial support from their fellow citizens as well.

Experiencing meaningfulness and support is likely to strengthen their resilience to the losses, and the somatic and psychological injuries that they suffered. As we had expected, the governmental employees rapidly saw their particular role: by strong efforts in their work to rebuild the level of functioning of their bureaucracy in order to repair the destruction that the terrorist had inflicted. Many of the political youths also spontaneously took on the participant role, some seeing themselves as resistance fighters for democracy and human rights.

In contrast to these attitudes, the various health professions appeared in their work with the victims of terrorism to treat them like other victims of criminal violence. *Why was the opportunity lost in making the victims aware of the other aspects of the ordeal they had gone through?* Was it restraint in order to protect the victim identity?

A more likely reason seems to be the lack among Norwegian health professionals in knowledge and experience of what distinguishes political violence from ordinary criminal violence.

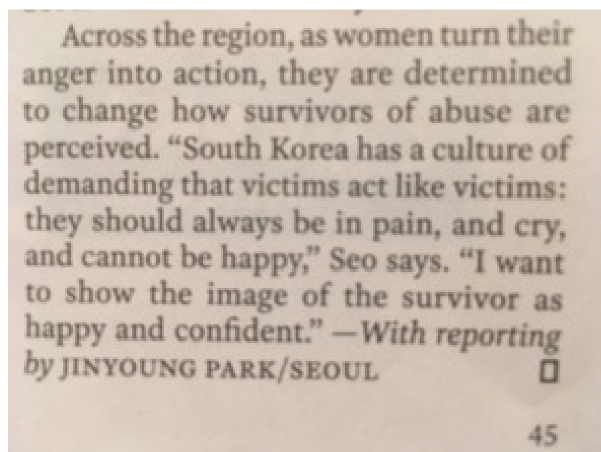
Compared to terror attacks during times of peace, it is easier to understand that when one's nation is attacked in war, crucial values such as freedom are at stake. This insight was, for example, demonstrated by the Norwegian concentration camp prisoners during WWII, when they named themselves "the third front" (in addition to "the exile front" and "the home front"). Thus, they took on the role of active participants.

There are some problems linked to the role of a victim: It begs for passivity and loss of responsibility for one's further life. However, I would like to underscore that the therapist in the beginning has to be cautious not to stress too much the role as a participant with its inherent more active part besides the victim part. In some cases, this can induce a feeling of bad conscience and shame for not living up to common ideals. In a funeral for a person killed in an act of terror, a remark that the death was not meaningless, most often will be quite out of place.

The term "survivor" for those who want to cope with a trauma psychologically, is now extensively used. I can appreciate this, but it is also confusing because it takes away the obvious meaning of being someone who has survived the real, physical danger. Language matters! ■

Lars Weisæth, Professor emeritus at the University of Oslo

The editor: *As an illustration of the ubiquitous presence of this topic, the following paragraph was found in an article about #MeToo in this week's Time Magazine, October 29, 2018:*



Across the region, as women turn their anger into action, they are determined to change how survivors of abuse are perceived. "South Korea has a culture of demanding that victims act like victims: they should always be in pain, and cry, and cannot be happy," Seo says. "I want to show the image of the survivor as happy and confident." —*With reporting by* JINYOUNG PARK/SEOUL ☐

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Is there a border between mental disorders and well-being?

– Supporting a psychiatric patient in a process of recovery

Esa Nordling

Esa Nordling
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Although there has been some development in methods of psychiatric treatment, the results have not always been as good as was expected. Follow-up studies have shown that for instance only 20-30 per cent of the patients with schizophrenia recover completely or almost completely. The treatment system includes a number of factors that hinder the process of recovery. The focus in treatment may be unilaterally based on a bio-psychiatric orientation, there might be difficulties in getting treatment in a decent time, the fragmentation of the service system may complicate the realisation of plans made for the patients, or there may be a number of bureaucratic guidelines and restrictions, that are not based on patients' needs. Recovery from a severe psychiatric illness is always a unique process, in which a person's day-to-day psychological, social and spiritual needs and support have to be considered.

The recovery has been conceptualised in three ways.

Clinical recovery is defined as a perspective where patients' mental state is improved or stabilised with medication and risk-management interventions. Clinical recovery is measured by symptom remission, insight gain, absence of relapse, and mastery in daily living skills.

Service-defined recovery is defined as a concept designated by the organisation where administrative and financially driven goals shape practice. Ser-

vice-defined recovery is viewed as a tool of cost reduction and it is measured by service throughput and service accessibility. Clinical recovery and service-defined recovery are often bound together and represent the traditional aspect of recovery from a mental disorder.

Personal recovery is defined as a holistic approach where individuality takes precedence, and staff and service users work in a partnership. It is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and social roles. It is a way of living a satisfying, hopeful, and contributing life within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the effects of mental illness. In mental health work, recovery requires a new framework of action and thinking. Resources, social involvement, hope, meaningfulness and positive mental health are considered to be central issues.

Studies on the processes of personal recovery have shown that there are at least *five central processes that affect how a person's recovery can be advanced* — connectedness, hope and optimism about the future, identity, meaning in life, and empowerment. If the goal of mental health professionals is to support recovery, they should evaluate their work practices on the basis of how those practices promote the processes of recovery.

Feeling of connectedness can be promoted by utilising peer support or by reconstructing relationships with family members, relatives, or friends, that may have been distressed in the past. Discussing patients' dreams and their many meanings can increase hope and optimism. In psychiatry, discussions of these topics are often avoided, because of the risk that they may generate unrealistic goals in patients' mind. This has often led to a situation, where patients suffer from a lack of future prospects or are disinterested in things that are important in daily living. Everyone has a right to dream, regardless of whether one has a mental illness or not.

The change of identity generally requires experiences of success in things that are personally valued. Many experts have told about their experience that acting as an expert and getting feedback has positively changed their self-concept and beliefs in personal potential. Meaningfulness and social involvement is related to the feeling of purpose in life. Social involvement means that one has a feeling of belonging to a group or to an action, where one can have understanding and approval of other people or where one can share experiences and feelings. Mental health professionals can strengthen psychiatric patients' social involvement with recovery-oriented practices. This can be realised by mapping and activating social networks, promoting opportunities to peer support and by supporting patients' interest in different alternatives of civil action. Empowerment in turn is a process, which is often a consequence of the processes described above.

There is a difference between *clinical recovery and personal recovery.* In the former, mental health is evaluated by the lack of disorders and symptoms. In the latter, mental health is evaluated in a broader context of mental wellbeing. Clinical recovery is evaluated using various measures of symptoms and personal recovery is evaluated with qualities of positive mental health. Positive mental health abandons the idea that mental health and mental disorders are on opposite ends of the same dimension. It is based on an understanding that well-being and disorders of the mind are two different dimensions. In positive mental health a person is described through strengths and resources of mind. For instance, a person with schizophrenia may experience happiness, meaningfulness, and closeness with other people, in spite of having a number of delusional symptoms. On the other hand, a person without a psychiatric diagnosis may struggle with feelings of unhappiness, solitude and lack of motivation, caused for example by work fatigue.

Mental health should be evaluated through both these dimensions. This requires use of measurement tools that allow us to identify psychiatric symptoms as well as evaluate mental well-being. An example of measurement for mental well-being is the WEMWBS scale (Warwick-Edinburgh Mental Well-Being Scale), which lately has gained positive attention in Finland and has been used in various studies. There are also many English language measures that can be used to evaluate personal recovery and implementation of principles of recovery orientation on organisational and systemic levels. The problem is that the translations of the measures lack national context and therefore there is not enough information on how valid they are within different cultures.

Even though mental health services have a big impact on beginning and advancing personal recovery processes, recovery may also occur in spite of services. If this is the case, things that are necessary for managing everyday life are central (e.g. proper income, good living conditions, diverse possibilities for recreational hobbies, and opportunities for meaningful action or work-life). Fulfilment of these conditions require social policies and legislation that takes into consideration the human rights and equality of mental health patients. ■

Graduation

– a professional border crossing? An interview with Janne Vuononvirta

Hanna Tytärniemi

One year ago Janne Vuononvirta graduated from a psychiatrist residency program and from cognitive therapist training. Residency may seem like a long process at first but is graduation an actual border to cross? And what happens after becoming a specialist?

Janne Vuononvirta
32 years. Turku University Hospital, acute outpatient care. MD, psychiatrist, cognitive therapist. Dedicated Taekwon-Do instructor and head coach at Turku ITF Taekwon-Do. In training to become a mindfulness instructor.

"Getting a specialist degree is actually more about getting a qualification to do the same work that you have done for a long time already" says Janne. This seems to be a common experience among many early career psychiatrists, at least in Finland. We become specialists each at our individual schedules instead of graduating as a bigger group or course. The celebrations are simple and usually dealt by delivering a cake to your work place and only a few have an actual celebration party with friends and family.

– Have you noticed any change in your own behaviour or attitudes from others after you have become a specialist?

"Not in the attitudes of others. I think my professional identity has been quite firm and stable for some time already and it's not titles that make the difference. Anyhow when you're training you always have it in your mind that you are about to become something. After my graduation I have felt some sort of emptiness. Now I am that something but what is that something? Am I supposed to be ready now? Is this the best version of me? Is this how it will be for the rest of my career? Thinking these question is a bit frightening and disappointing."

– How about becoming a therapist?

"I think I'm a better psychiatrist having studied cognitive therapy for four years. You have a much deeper psychological understanding of patients' situations and symptoms and it is easier to see pathways towards recovery. I try to bring therapeutic touch in the interaction with patients. However there is a certain down-side of getting psychotherapy training – you are beginning to know more, sometimes too much, but can't always put your knowledge into action due to the lack time and resources.

– You graduated as a psychotherapist and a psychiatrist on exactly the same day, even though these are distinct training programs from different organi-

zations. Were there a lot of differences in the training processes?

"Psychotherapy training was a clear entity and the training proceeded in certain order and followed a schedule. The studies were conducted similarly for the whole group and you also had the same group supporting you from the beginning to the end. Whereas the psychiatrist residency program was very individual, especially in my case, I did my training in three different cities from Lapland to Southern Finland.

– There are also some differences in the psychiatrist residency programs of separate universities. Based on your learning experience, would you rather see some changes in specialist training program?

"We now have one single final exam. Learning could be more efficient with separate modules, clear learning objectives, and several smaller exams in the course of studies. At the moment the training emphasizes theoretical knowledge. How you put that knowledge into action or communicate with patients is not evaluated. This is a shortage."

I have been Janne's co-worker a few times and I admire him a lot as a colleague. One of his superiors once said: "We need more young doctors like him. He is innovative and interested in improving treatment processes." Often Janne seems to find the right words in the right moment and he seems to be a strong person without the need to be on stage all the time. He has a long background in martial arts, he is a Taekwon-Do instructor and a black-belt taekwondoka.

– Is martial arts your source of inner strength?

"It's definitely one of them! I started Taekwon-Do when I was 13. Before that I was quite clumsy in sports. I was always losing the skiing competitions we used to have at school. This hobby has given me a lot of self-confidence and moments of exceeding myself. My experience as a Taekwon-Do instructor helps me as a doctor as well. For example, it feels quite natural to guide medical students at work after instructing people at a different field earlier."

– You have travelled several times to India and among other things attended "The School of Wisdom" there. Eastern thinking must have great influence in your life? "I have been interested in spirituality since I was a child, nowadays mostly in theosophy and Buddhism but also in western esoteric traditions. I believe that we human beings are more than just bodies. We are eternal beings who return here on Earth again and again to learn and gain wisdom. We are all connected in many ways. This belief (even though it may be impossible to validate by science) gives me a sense of purpose and inner balance.

– You are also training to become a mindfulness instructor. Are you planning to use mindfulness more in your work as a clinical psychiatrist?

"Heh, mindfulness seems to be an area where my two big interests – spirituality and psychiatry – collide. It seems that mindfulness could be useful in the treatment of various psychiatric disorder. However, it's important to acknowledge that despite numerous similarities, medical mindfulness is used in a different manner and for another purpose than religious mindfulness, e.g. in Buddhism. There is a group of patients who might benefit from mindfulness courses, especially in primary care, I think. Those patients who end up meeting a psychiatrist have usually more severe disorders and mindfulness alone is rarely enough for them."

– It seems that you are craving for challenges in life! Do you have some future goals?

"Hmm, I'm living a period in my life where I have already achieved my previous professional goals. Now there is a feeling of satisfaction but also emptiness. I have been a very goal-oriented person and now I try to live with fewer goals and enjoy what I already have. Relax and breathe. At least until I have figured out what I want to do next!" ■

Sacrifice, order and violence

Hans Christian Sørhaug

Medicine is always practised within a social context, and doctors often take both their own position and their technical terms for granted. Therefore, we have asked the social anthropologist, Professor Hans Christian "Tian" Sørhaug of the University of Oslo, to describe in non-medical terms the concepts of *boundary and victim*. Here is his contribution:

Hans Christian Sørhaug
Professor emeritus in sociology, University of Oslo, Norway

A ritual approach to the design of boundaries

A *ritual* perspective can never provide the whole and only truth, but it may deliver insights that other, more rationalistic perspectives has a tendency to hide. The renowned anthropologist, Mary Douglas, defines ritual as "an outer guarantee of a shared inner reality". Together with commensality (the act of eating together), *sacrifice* is an old, archaic and pervasive form of ritual. It is a basic cultural operation in the constitution of society in itself. Social order can be expressed, maintained and restored by sacrifice, and they will often be combined with rituals of commensality.

Scapegoating is a fundamental kind of sacrifice. Certain objects – things, animals and even human beings – are endowed with specific properties, which are experienced as vehicles for disruptive forces. Problems of disruption can thus be solved and resolved by the destruction of relevant consecrated objects. Sacrifice is a process of scapegoating where *belief* in the sacred, the practice of *violence* and the conception

of *order* are tightly integrated (René Girard). Order is based on *boundaries,* and violence may be defined as a transgression of boundaries. Ritual violence is endemic, but it can be stopped by the destruction of the scapegoat. Violence can stop violence.

In processes of consecration, capacities of disruption are being transferred to the properties of the goat. Forces of disruption are difficult to deal with – in comparison it is easy to kill a goat. The goat is a *victim* of collective projections turning it into an object attributed with magic or supernatural properties. The validity of the ritual is entirely indifferent to questions regarding the "objective" guilt of the goat. The ritual is run by a proxy logic providing itself with its own sense of objective reality.

Many discourses of *migration* can have this form. Migration is about persons crossing national boundaries, thus challenging and threatening principles of sovereignty. The sovereign is "the national body" with a monopoly on the deciding of who is on the inside and outside of basic boundaries. This is without doubt a holy principle in modern national states. Sacrifice is organized to save us from a chaotic stateless condition. In the present global situation characterized by a rather extreme mobility, the need for a sense of order strictly regulating transitions between inside and outside increases the demand for boundary objects with prescribed sacred qualities.

Political strategies construct boundary objects like policies of integration, elaborate reception procedures, isolated camps and long and tall walls, which are difficult to climb. They are spaces (events) for the management (worship) of sacred boundaries themselves creating the problems they are designed to solve. The public purpose of these "holy places of sovereignty" may well be integration, but the shifting line between transformation and transgression can indeed be difficult to toe.

This development is not a one-way street. To access necessary resources, migrants may find it opportune to describe and present themselves to different agencies as *victims.* Being victims in a correct way can make them into objects of assistance and support. The tactics of self-sacrifice thus become a mode of survival and a possible road to hope and autonomy. Sacrifice and victimization appear to be a top-down and one-sided interaction. The stateless person is left unprotected by critical boundaries. The powerless person is perceived as being crushed by the powerful system. Self-sacrifice is a bottom-up interaction, but the powerlessness of the victim can empower the victim by formal accessing of help from different agencies. If a need is correctly described by the migrant, the relevant agency is obliged to satisfy it. At least for a moment the object can be turned into a subject.

There is however a cost. Self-sacrifice is still a sacrifice. Even if it is done by yourself, it is done *to* yourself. Making oneself more worth by being a victim without boundaries can make oneself less worth as oneself. The logic is negative and self-affirming. The stateless person is not only powerless, s/he can end up as personless.

It is too easy to interpret sacrifice as a universal and deterministic social mechanism which is impossible to avoid or change, thus making violence inevitable. It is not, but it is a powerful and vicious cultural trap nearly impossible to escape, if it is not reflexively described and conceived. ■

Offline

Imran Rashid. Interview by Marianne Kastrup

In 2018 there are as many smartphones/tablets as there are human beings on the planet. The development of the new technology and the emergence of social media have transformed our world as we knew it. Imran Rashid has as one of the few from the medical profession in Denmark focussed upon the significant consequences this development has on our health, and in his book from 2017 he questioned our relationship with the smartphone and called for a change and an urgent need for mental restitution. The book will in a few months be published at Wiley in an updated international version named "Offline – free your mind of social media and smartphone stress" and contains – among other things – an overview of more than 300 scientific articles on the association between social media and smartphones usage and mental health.

It is said "Be healthy, be mobile" or "be = he@lthy: be mobile" – are you not too concerned?

The answer is a clear "no". As members of the medical profession we should recognize that within the last decades there has been an increasing control and focus on the Pharma industry when e.g. marketing new drugs that may have an influence on the functioning of our brain. When it comes to the tech industry there seems to be no limit for their products and how they can access our minds. I think that it is high time to look at this very critically. You could say that many of the new products, apps, etc. all are controlling our expectations – like a form of ludomania. We allow that they grasp our attention, we cannot resist the temptation and the constant dopamine kick made by turning expectation into a drug – and this is the major challenge.

So, what do you see is the problem?

There are many aspects – we may see unwanted biological, psychological, as well as social consequences. We are all faced with what I call a "Digital fragmentation syndrome" (DFRAG) – by that I mean that when more and more people – and I am talking about well-functioning persons – are constantly jumping in and out of time, place and consciousness level they may start losing grip of relevant questions like who are you, where are you and what is your purpose in life, what are your priorities?

From a biological perspective, many problems relate to the lack of sleep or abrupt sleep due to constant checking your phone and exposure to light before bedtime, which may result in increased stress. It has also been demonstrated that the cortisol level is reduced at a slower rate when returning home from work and trying to relax using social media compared to reading a book.

Psychologically, over time, you develop unhealthy digital habits and may lose your ability to concentrate for longer periods of time or easily get absorbed in irrelevant topics. You tend to become restless, and you may become too concerned with what others think of you or feeling inferior looking at the glorified life your friends upload on Instagram.

We also see what is called "skin hunger" meaning that we experience negative consequences of having less and less physical contact, resulting in an oxytocin shortage.

Are the consequences more pronounced in the younger generation?

Recently I carried out a survey of 787 high school students in Denmark. About 65% repeatedly checked their phone without really knowing why they did it, it was not a conscious decision, and about 54% had

Imran Rashid
Imran Rashid is a specialist in general medicine, an IT-tech serial entrepreneur columnist at a major Danish newspaper and author of the Danish book "SLUK – kunsten at overleve i en digital verden" (Offline – the art to survive in a digital world).

what I describe as "phantom pocket vibrations" meaning that they felt the phone vibrate in their pocket even if there wasn't actually anything on it. Nevertheless, when asked, about 93% claimed that they believed that they controlled their phone – not vice versa, despite that their actual behaviour showed that this certainly was not the case.

There is now evidence that normal children with very heavy use of the smartphone may even develop behaviour that resembles ADHD with difficulties in concentrating and keeping focus.

Let me remind you of the famous marshmallow test. It has been clearly shown that children who can handle impulsive temptations and not immediately give in fare better in many areas later in life. The modern technology could be seen as a digital marshmallow, but because it is not causing caries or weight gain it becomes even more risky and potentially harmful by constantly depleting our impulse control.

In a lecture to about 200 pediatricians I asked if they could name an app that they saw as "healthy" for children, but knowledge about the technology was not very prevalent and this I see as a serious problem. We as doctors have far too little knowledge about the drawbacks of the new technology and the dangers to public health.

What do you see as a way forward?

Look at how public health issues such as smoking regulations and wearing seat belts have changed over the last decades. I see the present use of modern technology and social media as a major public health problem that we must face and control and not just let commercial interest govern the use.

In the medical profession I think that medical students should learn about technology and its impact on our physical and mental health.

It is interesting, however, that some companies now understand some of these drawbacks. As an example, Apple has in their new software update, iOS 12.0 included a functionality called Screentime, which helps you monitor how you use your phone, and let you limit usage of certain apps, so you become more conscious of your usage.

You have focused on the negative consequences; don't you see any positive?

Certainly, modern technology is a major achievement in daily communication. And it should be used consciously. You could say that artificial intelligence should support human intelligence for the benefit of mankind. We see how virtual reality may help many psychiatric conditions such as agoraphobia, how Virtual Avatar Therapy may be beneficial in the treatment of PTSD or schizophrenia. All this will develop very fast – and that is positive, what I am concerned about is the more or less automated use of social media and phones we see right now and the reluctance to control it. ■

The challenges of cultural trauma

Danutė Gailienė

Foreword by Ramunė Mazaliauskienė
Lithuania and the other Baltic states have a sad history, and this history has long-lasting consequences. In her works, Professor Danutè Gailienè evaluates these consequences of trauma and its impact on certain groups in the society and cultural identity of Lithuanian people.

On October 6th, 2018, in Vilnius, the capital of Lithuania, a coffin covered with the state flag is solemnly brought to the Vilnius Cathedral on a caisson. The country is saying farewell to the last leader of the guerilla fighters, the General Adolfas Ramanauskas, code name Vanagas (The Hawk). He is buried in the Antakalnis Cemetery, where state leaders rest.

Ramanauskas-Vanagas led the Lithuanian armed resistance against the Soviet occupation in 1944, at the last stage of the already-lost war. He stayed alive and managed to hide for several years. Betrayed by a former classmate, arrested by the Soviets and imprisoned at the KGB jail in Vilnius, he suffered cruel torture, was killed and put in the ground somewhere in secret. Only in 2018 did the researchers manage to find the place and identify the remains of the leader of the guerilla fighters. Almost three decades after restoring the independence of Lithuania, the general was finally put to rest with full honours.

This scene contains a huge quantity of historic and symbolic meaning. First, it is an important step in Lithuania's overcoming cultural trauma and restoring a healthy cultural identity. A cultural trauma is the destruction of a society's cultural identity. As the cultural protection fails, the protective social and cultural connections are severed, and people remain lonely. A trauma destroys the integrity of an individual psyche, triggers defence and compensation mechanisms. They make actions and symbolic rituals public and are significant in overcoming trauma. They foster solidarity among people, indicate the shared nature of the experiences, structure and help overcome complicated moments of personal and societal transformation.

Like other Baltic states, Lithuania in the 20th century experienced multiple historic disruptions that have caused cultural traumas. Cultural trauma inhibits the continuity of the collective memory and the intergenerational transference of historic memory, the connections between family and society, between the various social groups, between generations. If not overcome, they may last for a long time and even be transferred to later generations, disrupting the normal psychological development of individuals for long periods of time.

The occupations (the first Soviet in 1940, the Nazi in 1941-44, the second Soviet from 1944 onwards) lasted for five decades, until the country restored its independence in 1990. The Soviet regime had a strong impact on the society. Half the Lithuanian population indicated having directly experienced political repressions in their family, and everyone was forced to adjust to totalitarianism. The regime paid much effort not only to quench the resistance of the people, but also to win their loyalty. The system of education based on ideology controlled youth and other public organizations, the propaganda machine, and total surveillance of the citizens and isolation from the free world, all served the purpose.

First came direct repressions in order to destroy and isolate the members and even groups of the society that were potentially disloyal and capable of resistance against the regime, and at the same time to intimidate the remaining citizens. Members of political parties

and public organizations, professors, teachers, large land owners and their families, the clergy and other were killed or deported to Siberia and other remote locations in Russia. After Stalin's death in 1953, the repressions grew milder, partly also because the majority of "public enemies" were already destroyed. But the people who returned from prisons and deportations were still treated as "public enemies", and so were their children. They faced obstacles on their way back to Lithuania, were persecuted, discriminated against and slandered. Often an unusual atmosphere developed within families, as parents hid their past from their children for political reasons, in order to protect them. Some only learned about their family history as adults and after the restoration of independence, some knew or sensed it, but experienced constant insecurity and anxiety. Some revealed their traumatic history only during the process of psychotherapy.

Psychotraumatology studies carried out at the Vilnius University have revealed that the traumatic experience of the people repressed by the regime is much heavier than that of the non-repressed (they experienced more torture, persecutions, and humiliations). Until now, they keep experiencing somatic, psychological, and social problems. It also emerged that even the people who have not experienced official political repressions and simply lived under the conditions of the occupation in Lithuania have suffered — a quarter have lost someone close because of the repressions, as many as a third indicate that they failed to achieve their professional and educational goals because of the occupation, and they actually feel worse than political prisoners studied in other countries. They also indicate few factors that have helped them overcome difficulties in life. Mostly, they relied on the support of family and friends,

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is a professor of clinical psychology. Her research interests are in the fields of clinical psychology and suicidology. She initiated the very first studies on suicidology and psycho-traumatology in Lithuania, and her special interest is traumatising effects of long-term traumatisation. She is an author of many articles and books.

In this article, Professor Danutė Gailienė talks about long-term consequences of cultural trauma due to destruction of social identity in Lithuanian society after the occupation of the country by Soviet Union.

meanwhile the people who experienced political repressions indicate more numerous coping factors — faith in God, political activity, the support of friends who have experienced the same repressions, hope and sense of moral superiority over their tormentors.

Thus, the effects of such long-lasting and massive traumatisation are complex. In order to study the intergenerational effects of trauma, we evaluated the health and psychological wellbeing indicators of the adult children of the repressed families. In the second generation, there was virtually no difference from control groups. Thus, clinical symptoms are not necessarily present in the second generation, and children of victims adapt quite well. But they demonstrate higher sensitivity and vulnerability. The adult children of repressed people indicate that during the years of the occupation they often experienced fear, anxiety, and discrimination. They felt that the repressions of their parents affect their own life. But they also indicate a very important positive aspect: from their parents they learned about the political system, the repressions, they knew the truth, and the family instilled very clear value positions. The studies have confirmed that the families who have experienced political repressions transfer important factors of psychological resilience to their children and grandchildren.

A large-scale (1000 participants) study of intergenerational transmission of resilience of a representative sample of the Lithuanian population revealed that the family history of the experience of repressions is an important predictor of the psychological well-being of the offspring. Members of the repressed families present as feeling better, are more optimistic and happier. The most important intergenerational protective factor against historical trauma is identification with one's family history. In turn, the study participants from non-repressed families had significantly less knowledge about the experiences of their family members and significantly less identified with their family history.

Thus, quantitative non-clinical studies of trauma and resilience demonstrate that the members of the second and third generations from politically repressed families are in a better psychological shape and are more hopeful. But as we see, a very important factor emerges — knowledge of family history. In Lithuania, the repressed families were the brightest, often with clear family values that they could pass on to their children and grandchildren.

On the society level, in terms of coping with cultural trauma, important data come from a study of a representative sample of three generations, 24 years after restoration of independence. It appears that the social transformations experienced are evaluated as rather positive. Both the older participants, born and raised during the years of the Soviet occupation, and the younger ones, who have grown up already in independent Lithuania, perceive them as more positive than negative, especially the youngest generation. That the society is quite mature is also indicated by the rather differentiated evaluations of reality, with both positive and negative aspects. Therefore, we can see that the society is gradually integrating the traumatic historic experiences and healing its cultural complexes.

We note that the effects of five decades of occupations and totalitarian regime are still present in the lives of individuals and society. Those who experienced direct political repressions and even their children still feel the effects of that traumatic experience. They also possess important protective factors — political activity, strong motivation to resist, and spiritual values. For this reason even heavily traumatised former political prisoners in some respects actually feel better than the people who experienced less repressions, and they transfer important resilience factors to their children.

As for the effects of cultural trauma — the traumatic experience of repression is less of a problem than the adjustment to the regime that is not even understood to be harmful by the people who adjusted. The effects of traumatization are indicated not by a larger prevalence of clinical post-traumatic diagnoses, but by cultural complexes, since it appears that the most important traumatic experience is the one that is yet unconscious.

In the first decades of the Soviet occupation a change in the Lithuanian people was perceived by political prisoners, returning from deportations and prisons. Memoirs described how people seemed changed, intimidated and folded inwards. In order to survive, people used subconscious defence mechanisms, cleverness, and pretense. In many cases, it helped survival and satisfaction of vital needs. But it is dangerous if this becomes a dominant life strategy, which may remain harmful in the second and even the third generations. The researchers speak of the still-present Soviet mentality, moral trauma and ambiguity. The general indicators reflecting the state of mental health of the society persist, such as the prevalence of self-destructive behaviours — suicides and other external causes of death, alcohol abuse, and bullying. Public discussions about the historic past often burst into aggression and hostility, which indicates that the cultural complexes that have not yet been overcome. Challenges in overcoming these traumas do persist. ■

Health promotion among refugee women

Interview with Solvig Ekblad

Marianne Kastrup

The interview describes how a relatively short and culturally tailored intervention with interdisciplinary health professionals, a local coordinator, a process evaluator, and a professional interpreter, will strengthen the prerequisites for increased health literacy and perceptions of health and quality of life among new-coming female refugees from countries outside the EU.

Why did you find it important to start such a project?

I have a long-lasting research interest in mental health problems of refugees, in particular female refugees. I was inspired when I discussed the issue with one of the top researchers in the field, Professor Richard Mollica from Harvard, who was involved in a psycho-educational project for patients coming from Cambodia. They were offered a five-sessions health promotion group. Changes between the pre- and post-health promotion groups demonstrated significant improvements in health status, lifestyle activities, sleep, and depression.

So we decided to start a similar Health Promotion Intervention Course (HPIC) in Sweden focusing on newly arrived refugees. Among refugees, female refugees are most prone to marginalisation. Thus, it was natural to pay particular attention to this group. It also turned out that it was relatively easy to find funding for studies on women.

What was the aim of the study?

We were interested in how participants perceived their health before and after attending a HPIC, and what were the participants' most important issues concerning health, personal care and the Swedish health care system? The HPIC is a group training course, in which participants receive professional information from clinically active nurses, physicians, physiotherapists, psychologists, midwives, dentists, social workers, and police. The underlying idea is the importance to understand individuals in their context.

Solvig Ekblad
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Photographer: Stefan Zimmerman

How did you recruit the participants?

I should emphasize that participants are newly arrived refugees, not patients, which means that they are

not selected because they are in need of help. We have had HPIC activities in several parts of Sweden, including a suburb of Stockholm, and in Angered/Gothenburg, Malmö, Kalmar, Visby, Växjö, and Uppsala. The recruitment has differed to some extent from town to town.

We have established collaboration with an NGO that was created by Alexandra Charles von Hofsten 20 years ago. She started a club (1.6 miljonerklubben.com) to promote women's health and got interested in the refugee aspects. This NGO has raised money and is actively involved in recruitment. Each intervention group comprises 8-14 persons, it is a closed group and everything that is revealed in the group stays in the group. Mobile phones are not accepted, and the session is divided into a first educational part, followed, after a refreshment break, by a general discussion and dialogue where the participants are encouraged to elaborate on what was taught. Some raise questions to gain knowledge, some questions express attitudes, and some are of an intimate character. The course comprises five sessions of two hours each. We have had groups in different languages: Arabic, Farsi, Somali, Thai, and English, each course focussing on one language.

How did you select the topics to be included in the programme?

We were inspired by Professors Mollica in USA and Silove in Australia, but we also interviewed women who came to Sweden some time ago asking them what information they missed as newly arrived. We have over time carried out certain modifications regarding the content of the different modules based upon the experiences gained and the needs of refugee women.

Presently we have five modules: 1. Children and family. 2. Human rights (including childrens' rights; Swedish legislation). 3. Women's physical health (including pregnancy, anti-conception, knowledge about how the body functions). 4. Women's mental health (including stress, trauma, recovery). 5. Nutrition, exercise, healthy life styles (including importance of physical activity; healthy cooking, abuse).

The coordinator administers a questionnaire to each participant during the first and last lessons of HPIC and by mail six months after HPIC, if funding is available. Health related quality of Life (HRQoL) is measured using EQ-5D self-assessment and focus group interviews after the lessons.

What have been the main findings?

Our study shows that this intervention shortly after resettlement for new-coming refugees is relevant and useful in terms of HRQoL and knowledge of the health care system as well as for stress management, coping, empowerment, and building trust. The study revealed that many participants describe post-migration stress, diseases, and treatment needs, but also a lack of trust in the Swedish health care system and problems in getting access to it. On the other hand, the results also suggest that with a relatively small investment, society can accomplish significant changes.

Based upon the evaluation of the present project of the first courses we found that many women wanted knowledge about the human rights of adults and children, and they misinterpreted the legislation as for the threshold for forcibly placing a child in custody. This has resulted in that migrant mothers may have been afraid to set limits for their children for fear of societal consequences. To be informed about rights by the police and a social worker during a session of the HPIC has proven very useful.

So, do you have any recommendations how to move forward?

We know that refugees face difficulties with regard to their right to health. Thus it is important that gender, human rights, and intercultural competence are part of education/training in medicine, health care, and social work. Furthermore, evidence-based knowledge should be part of the refugee reception programme. A Health Promotion Course run by trained medical staff for newly arrived refugees should be introduced, allowing them to take care of their own health and get to know the health care system. Adequately trained professional interpreters are needed, since lack of language skills can be a major barrier to understanding the functioning of the health system. Knowledge about the legislation and rights of children as well as adults is important to help parents managing their children.

Finally, I find it very positive that HPIC is the result of a productive interdisciplinary collaboration between university, NGOs, the health sector, police, and social welfare. ■

Changing identity

Shahram Shaygani

At a workshop on migrants' mental health initiated by then WPA president, Dinesh Bhugra, a colleague from Iran in Oslo last year contributed with his own story of crossing borders. Being a psychoanalyst, Shahram Shaygani also has a theoretical view on this topic. Currently Shahram is working as medical director for in-patients at Trasoppklinikken in Oslo, a clinic for dependency problems. Besides this, he has his own practice and he is also a consultant to a social services center in the Norwegian capital's East End.

Shahram Shaygani
Psychiatrist and psychoanalyst,
Medical director

I came to Norway as an asylum seeker in 1988. When someone asked me where I came from in the first years in Norway, the answer was very simple: "I am from Iran". The longer I stayed in Norway, I noticed that the answer to this question became longer and more complex. After a few years, my answer came as follows: "I'm from Iran, but have lived for many years in Norway". It was as if I wanted to emphasize both for the person who asked, but also for myself that something is about to happen to me in relation to the basic experience of where I belong.

In the last few years, my answer has become; "I'm a Norwegian-Iranian". As a psychoanalyst, I have never stopped to be fascinated by how the unconscious manifests itself in our language. In my first answer, "Norway" is absent. In the second answer, Norway came as No. 2 in the order of the countries I mention (Iran first, then Norway). In the third answer, "Norway" comes first.

It took me 30 years to develop such a response. I think my answers reveal that identity is a dynamic component of personality that develops with time and in relationship with other people. Time and relationship are two important facets that, in interaction with each other, determine how the identity of an immigrant in his/her new country will develop. It takes time for an immigrant to establish attachment to his/her new country, while the time this connection takes, depends on the quality of the relationship the immigrant is able to establish.

The German philosopher Martin Heidegger made us aware of the deep, dialectical and dynamic relationship between the quality of existence and the world in which one lives. *Being* (the quality of existence) and the *world* are two complementary entities that interfere with each other constantly, according to Heidegger. Immigration is about moving from one world to another, and therefore changing of the quality of existence is eminent during the process of migration. Most of migrants leave the world they knew, to a world at least partly unknown. The meeting with the unknown can awaken many intense, difficult and contradictory feelings and thoughts in immigrants. From an existential perspective, migration is an *existential crisis*.

Like all existential crises, immigration has elements of loss, hardship and anxiety. Immigrants have to get through multiple experiences of loss, mourning, enduring long-term adversity and an existential fear. The existential anxiety of the immigrant is about meeting with the unknown, confronting meaninglessness, surviving loneliness and dealing with the freedom to choose his/her path and taking the responsibility for these choices. Existential philosophy tells us that anxiety is not just a sign of sickness. Existential anxiety is a driving force, showing us an *existential opening* towards a more authentic way of being-in-the-world. Therefore, immigration as an existential crisis invites the migrant towards a more complex, but perhaps also more authentic identity. How the migrant responds to this invitation, decides his/her changing of identity. ■

Interview with Professor Arūnas Germanavičius

Ramunė Mazaliauskienė

Dear Professor, for many years you have been working as a university professor and for almost a year you have been the head of a big mental hospital. You must have faced many difficulties due to “brain drain”. What is your general impression about this?

I accepted this challenging job at the end of December 2017. The largest state psychiatric hospital in Lithuania with 540 beds and 640 staff members, treating about 7000 patients each year, was built in 1903. All these people are housed in old infrastructure with huge corridors, big rooms, a very limited privacy, and almost no milieu therapy. Each year we have 20-30 psychiatric residents in training, some later returning as assistant psychiatrists.

This creates a very special atmosphere with nineteenth century buildings, built as specialised psychiatric hospital. It spawns huge park surroundings (from the air it remembers the coat-of-arms of the Russian Empire with its two-headed eagle). Young doctors read the latest editions of Maudsley Guidelines, NICE recommendations, and other evidence-based literature. Other staff members do not have enough skills and motivation for effective management of patients with complex needs, nor do they work in multidisciplinary teams or share responsibilities. And so, young psychiatrists might burn out rather quickly, start to get disinterested and unmotivated, and not feeling responsible for good quality of care.

As a consequence, well-trained and often polyglot young Lithuanian psychiatrists look for job in Scandinavian countries, the UK, Germany, Netherlands, and France. Of course, this is a big challenge for the hospital management, and we must be prepared to compete in the global market. This is the price that small countries, like Lithuania, Latvia, and Estonia, have to pay for freedom, which is no doubt, our ultimate value. And personally, I am very happy to partake in these interesting times!

Since June 2018, our hospital has raised salaries for doctors and nurses by at least 20% and started to create motivational packages developing psychosocial treatment skills, implementing modern management methods to prevent further brain drain. This new policy will be evaluated next year, but so far results are quite positive, and another three young psychiatrists recently joined our team. With regard to psychologists, social workers, ergotherapists, art therapists and so on, problems of shortage of staff are not that acute.

What consequences will the Lithuanian mental health system face due to emigration of specialists?

This is an acute and severe problem, occurring now in the state healthcare system. However, I also see a positive side of emigration of Lithuanian psychiatrists. Openness to different ideas, creativity, and ability to embrace other cultures and societies, are all important skills that develop when abroad. Also, some psychiatrists working abroad establish connections with our hospital, giving advices for management, sharing their experience, sometimes coming back. In particular, I enjoy discussions with doctor Martynas Andrijevskis, who is helping us to implement some principles from LEAN management using his experience as a UK NHS child-and-adolescent psychiatrist, and Vytas Blažys, also a child-and-adolescent psychiatrist, who after serving 10 years in UK NHS decided to come back to Vilnius and work as supervisor in our hospital. Also very valuable to us are visits and advices by doctor Darius Mardosas, manager of mental health centre in Glostrup hospital in Copenhagen.

As a professor in the university you know the needs of young people who study psychiatry. What are their expectations for a future career?

Young people usually do have ambitious goals, but our healthcare system has no tradition of evaluation. This lack also concerns training. We have started to regularly evaluate their expectations, and I am especially interested in their experience of work in our hospital. We started open discussions on what is lacking and what they find useful. Many wish to acquire diagnostic and psychotherapeutic skills and gain knowledge about biological methods of treatment, and social and cognitive rehabilitation. Working in multidiscplinary teams after graduation from medical faculty is challenging for young doctors, because at the university they do not get this type of training. Some are interested in developing research skills. Collaboration and empowerment of patients' carers are currently hot topics since there is no universal understanding of how it should be done, even among residency teachers. Collaboration with and involvement of carers may be problematic because some carers wish that only patients must be the objects of treatment. This is the case especially in the area of substance dependencies, but also in other areas in psychiatry. Psychiatric residents are open and sometimes very critical about the learning environment, and we try hard to meet these needs.

Thinking about the identity of a psychiatrist – as an effective manager and communicator – is still to be developed in Lithuanian psychiatric training. I do observe some clash between generations regarding human values when discussing with residents and old generation psychiatrists as they meet with "special" patients or themes. It may concern homosexuality, end of life decisions, spirituality, autonomy of patients with severe mental illness, and how and when to advise patient to stop medication. For example, some experienced psychiatrists think that they are not obliged to offer emotional help to a patient after so-called para-suicide attempt (meaning non-serious intended self harm) and that only psychologists should do this since "psychiatry is a medical profession". I am happy that younger colleagues do not share this kind of attitude.

Arūnas Germanavičius

MD, PhD, graduated in 1994 from Vilnius university (Lithuania), and has been trained as adult psychiatrist, partly in clinics in Greifswald (Germany) and Zürich (Switzerland). Prof. A. Germanavičius has 20 years of experience in clinical psychiatry, research and training of professionals in mental health. His research focus on the development and evaluation of community-based services for people with SMI, psychosocial rehabilitation, social psychiatry, public mental health, suicide prevention, human rights and stigma. He has been involved in regional projects (in Estonia, Latvia, Lithuania and Kaliningrad region Russia), as well as into 7 EU research projects on mental health (project acronyms: EMILIA, POMONA-2, HELPS, ITHACA, INDIGO, ASPEN, SUPREME), and COST project on forensic psychiatry. Dr. Germanavičius is one of the authors of the National Strategy on Mental Health (adopted by Lithuanian Parliament in 2007), and co-authored several laws and guidelines in psychiatry. He co-authored 3 textbooks and more than 30 research articles, two of them were awarded by international prices (in 2011 and 2012). He is editorial board member of several journals, including Nordic Journal of Psychiatry. Since 22 December 2017 he works as director of Republican Vilnius psychiatric hospital.

Also, young psychiatrists are more sensible to patients with psychological traumas that more experienced colleagues sometimes tend to neglect, focussing on biological treatment methods. I do have some clues that this might concern a Soviet trauma of the older generations, but we need more research about this phenomenon among psychiatrists.

What can be made in order to stop the migration of mental health specialists?

Stopping migration is not possible. But we can motivate young professionals either to stay in Lithuania, or to come back after their experience abroad. To a large extent this will depend on the postgraduate training at Lithuania‘s two universities. Are four years of training programmes adequate and does this meet the needs of residents? Currently, there are some differences between Kaunas and Vilnius as for the content and style of training, despite having the same duration. Another important measure is a structural reform in the whole healthcare system; it is not just about increasing doctor's and nurses' salaries. It is about creating a new open but also effective culture of decision-making between managers of LT NHS and staff, and between politicians, Ministry of Health, State insurance ("Sick Fund"), and Academia.

What are other alternatives to guarantee adequate mental health care with limited human resources?

Everybody is looking for this answer, and I don't know where the true solutions lie. There are some altrnatives – empowerment and increasing knowledge and skills of carers and family members of patients. I think that Estonia has started a good implementation project on first episode psychosis, and Lithuania should follow its example.

At the population level, self-management for mild and moderate symptoms of anxiety, insomnia, and mood disorders, is currently possible through mobile platforms as self-help apps. This is rather underdeveloped in Lithuania. Furthermore, transferring functions previously being run by psychiatrists to family doctors, mental health nurses, and psychologists, is a not-yet-done-homework in Lithuania, that should be taken care of in the near future.

Can you mention three urgent steps to be taken in order to improve situation in this field?

a. Training medical students, future psychiatrists, and psychologists on human rights and patient empowerment methods, that could be used in practice and complement psychosocial methods. Dealing with institutions linked to stigma and exclusion. Social care homes, which according to professor Graham Thornicroft "are neither social, nor care", should be used only in exceptional cases, and only when psychiatric rehabilitation in the community has failed after two years.

b. Using expensive psychiatric in-patient beds more effectively, and to involve primary mental health care into shared responsibilities for using beds appropriately. Maybe budgets for primary mental health care centres should be linked with usage of secondary level in-patient beds of regional hospital in the respective catchment areas.

c. Creating a system of evaluation of state-financed universities, using a 10-years follow-up of career results of graduates (some US universities have this system). ■

The Norwegian psychology model. How psychologists crossed the borders

Andreas Ringen

In Norway, there are now more psychologists than physicians working in specialized mental health care. Member of the board of the Norwegian Psychiatric Association, Andreas Ringen, MD, PhD, has looked into this phenomenon – both its causes and effects. He is working as the medical director of the in-patient unit of Oslo University Hospital, mostly responsible for persons with psychosis. He has previously chaired the association's Section for Ethics and Philosophy. Here are his reflections on this crossing of borders.

Andreas Ringen
MD, PhD. Oslo University Hospital, Oslo, Norway

In the year 2000, the old Law for Physicians was replaced with the new Law for Health Personnel. In the new law, physicians were only one of many types of health personnel to be listed as members of a common legal category with equal obligations and privileges, reflecting the rising New Public Management profession-independent view on health care administration.

A total revised Mental Health Law followed in 2001. Psychologists with "specialisation in clinical psychology" could now have the formal role as Responsible for Legal Decisions ("faglig ansvarlig for vedtak"), formerly assigned to psychiatrists only. These psychologists can from then on decide independently if a person should receive compulsory treatment and make all kinds of other decisions requiring a formal decision as defined in the law – including decisions on compulsory nutrition. The only exception being that psychiatrists still should be the only profession to make decisions about compulsory treatment with medications.

By 2001, The Norwegian Psychologists' Association had for many years worked for a higher formal status for psychologists in the clinical hierarchy, equal to the role of physicians. Their strategy seems to have been well planned and executed, including active engagement in the media and with politicians. A crucial part of this strategy was to create public acknowledgement of a formal psychological clinical specialisation mimicking the system of the medical profession. Actually, the Psychologists' Association have been able to maintain full control over the curriculum and the authori-

sation to become a specialist. This is in contrast to de medical specialities, where the Directorate of Health from 2018 decides everything. Another part of the strategy seems to have been to eliminate "psychiatry" or "psychiatric" from the official language, restraining the use to what is strictly related to the medical discipline of psychiatry. The main users' organisations have been their allies in this quest, as "psychiatry" in their ears carries stigma.

The politicians seem to have followed en suite. The Norwegian psychiatric health services are called Mental Health Care ("psykisk helsevern"), and 99 % of institutions have removed "psychiatry" or "psychiatric" from their names.

The Psychologists' Association declared that by the coming of the new laws, they were able to take a totally independent role in the evaluation and treatment of mental illness, just like physicians. Some argued that although the Law for Health Personnel was neutral regarding professions, the §4 still read that "When cooperating with other health personnel, a physician should decide in medical matters" and the physician still would have the last word. The Psychologists' Association retorted questioning the definition of "medical matters" and argued that "medical" should be understood as concerning the physical body or medications only, and claimed that a letter from the Ministry of Health decided matters in their favour.

The Psychologists' Association have also been good at arguing for more psychologists in the services. The national "step-up plan" for mental health care 1999-2008 allocated more resources to outpatient clinics. A major part of these funds were used to recruit psychologists. Formally a psychologist can do the same job as a physician and (still) at a lower salary. Psychologists are now the dominating profession in the Norwegian Mental Health care system. Furthermore, the Psychologists' Association is viewed by government as an equal entity as the Norwegian Medical Association (NMA). In the NMA, the psychiatrists are only a sub-association, traditionally with relatively little focus from the NMA leadership. This has made it possible for the Psychologists' Association to gain considerable political impact. The Government has decided that from 2020 every municipality must have a psychologist and the latest national budget allocates extra funds for hiring of these.

There was some debate between the NMA and the Psychologists' Association in the media at the time of the law changes, but since, the NMA and the Norwegian Psychiatric Association have held a low profile on these issues. Now, however, there is a rising concern among physicians working in psychiatry about being relatively few and being predominantly preoccupied with the limited task of supervising other professions' patients on somatic matters and medication. With the new focus on somatic comorbidity in the "package programmes" for mental health being introduced in Norway, the need for medical competency the bio-psycho-social way will again be highlighted. ■

Psychological practice in the Lithuanian health care system

Nijolė Goštautaitė Midttun

Applying psychological methods in clinical practice and research has a long history in Lithuania. The first practitioners of psychology in medicine were medical doctors, psychiatrists and other specialists, enthusiastic about psychological interventions as potential treatment methods. The first article in the journal "Medicine" entitled "Psychoanalysis and psychotherapy" was published by a professor of psychiatry, Juozas Blažys, one of the founders of the Society for Psycho-Techniques and Occupational Counselling (1931) and the author of the first Lithuanian handbook of psychiatry, published in 1935. These beginnings of professional psychology in medicine matured during the first independence between the two world wars and provided the foundation for the application of psychology in medicine, even during the Soviet occupation.

One of the defining moments for modern psychology in medicine in Lithuania was founding in 1973 of the Medical Psychology and Sociological Research Laboratory at Kaunas Cardiology Institute, devoted to implementation of large-scale epidemiological studies. The head of the Laboratory since its inception was Professor Antanas Goštautas, researcher, psychiatrist, and medical psychologist.

The first of such studies was The Kaunas Rotterdam Intervention Study (KRIS), investigating behavioural and operational components of health intervention programmes in 1972-1974. It was Initiated by a WHO team from the Division of Research in Epidemiology and Communications Science and implemented by Kaunas Medical Institute, Rotterdam Municipal Health Department, and Erasmus University. The psychological sub-program was implemented by the Laboratory mentioned above and focused on developing international methodology, concepts, definitions, and interventions for psychological risk factors in health, stress, psychosocial adjustment, lifestyle, and behaviour. Its overall aim was to reduce morbidity and mortality. The study provided important evidence that psychological targets and interventions could positively impact heart disease morbidity, and that such an impact might be cross-culturally valid, even in so radically different health care systems.

Another large-scale study was the Multifactor intervention study for prevention of myocardial infarction and stroke (later CINDI), which introduced systemic and multidisciplinary approach in medicine, internationally comparable methods, and standardization of interventions. Focus was on reduction of mortality from cardiovascular disease. In 1984 the international program Monitoring of Cardiovascular Diseases (MONICA) was launched, which had integrated a strong psychological component – MONICA-PSY.

All these programs have facilitated further research within the framework of the Laboratory for Medical Psychology and Sociological Research. Results have covered counselling interventions, relaxation techniques, stress and "type A personality", and diagnostic assessments in psychiatry. There were systematic attempts to facilitate multidisciplinary approaches in clinical practice, such as training nurses to deliver psychological interventions for behavioural risk factors in cardiovascular health. Focus on stress and coping, behaviour and lifestyle change, counselling to achieve

smoking cessation and a healthy weight, as well as psychological techniques to promote health of schoolchildren have all provided pathways of integrating psychology and medicine. A health psychology master program founded at Vytautas Magnus University (Kaunas, Lithuania) in 1998 has been built on the basis of research and concepts advanced in the Laboratory.

Involvement in large multidisciplinary intervention studies provided incentives for a closer integration of psychology and medicine, and improved understanding of processes involved in behaviour change and relationship with outcomes in medicine. These studies did not only introduce standardised psychological testing (such as MMPI clinical scales and cognitive tests), but also provided a conceptual framework for standardised psychological interventions in medicine and a multidisciplinary team approach.

The first psychologists began working in the health care facilities in Lithuania some 50 years ago. Since then, their presence, input, and influence has increased. Psychological methods and counselling are widely used in rehabilitation of physical illnesses and have become routine interventions in the care for mentally ill. Psychologists are regular members of the multidisciplinary teams in psychiatric services, and they are employed in all health care and social care institutions. Still, much of the routine work of a psychologist in the health care facility is focused on tests and assessments, which technically are not necessary for medical diagnosis, but they are part of old, established routines. There are several evidence-based psychological tests, but some admit that unscientific projection methods are still widely used. Psychological counselling services for patients with psychiatric diagnoses as well as for persons experiencing crisis, suicide ideation, and severe distress, are available through more than 100 municipal primary mental health centres.

After regaining independence in 1991, there was an explosion of interest in various counselling and

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graduated as a psychiatrist in 1997, acquired psychotherapy specialization in medicine in 2003 and a master degree in health psychology in 2004. She has worked as a psychiatrist in outpatient and inpatient psychiatric facilities in Lithuania and Norway, and also in private practice. Her current activities focus on public mental health, especially in the field of control policy for psychoactive substances, mental health promotion programs, advocacy, and stigma reduction in psychiatry. She has extensive training and experience ranging from teaching psychiatry for medical students, residents, nurses, and social workers, and also training of health care specialists in solution-focused counselling, psychosocial rehabilitation, addiction counselling, and art therapy. She has developed mental health at work programs and is involved in quality of life research. For many years she has been involved in drafting and commenting on legal acts regulating mental health care, including documents for professional qualifications. Member of the Lithuanian psychiatric association since 1996, board member 1998-2011, and newly elected 2018. Editor of the official journal of the Lithuanian Psychiatric Association “Psychiatric News” 2000-2011. Since 2016 board member of the NordAN (Nordic alcohol and drug policy network) and the president of the Lithuanian Tobacco and Alcohol Control Coalition. Director at Mental Health Initiative.

psychotherapy techniques – starting with numerous brands of psychoanalytic, humanistic, gestalt, cognitive-behavioural, but also drama-therapy, psycho-synthesis, and systemic family psychotherapy. Psychiatrists were enthusiastic early trainees and adopters of psychotherapeutic interventions, using them in addition to routine psychiatric services for several decades. Until now, use of psychotherapy for treatment purposes has to be delivered by a doctor, and for a long time it was certified as a narrow specialisation in medicine. Recently, psychologists have legally become health care service professionals, and medical psychologists have individual stamps.

Education of psychologists practicing in health care has developed dramatically in the past 30 years. The program of clinical psychology (the first and only) at Vilnius University was established in 1991, but a separate course had been taught for several decades before that at Kaunas Medical Institute (currently Lithuanian University of Health Sciences) and Vilnius University Psychiatry Department of Medical Psychology. A master program of health psychology was established at Kaunas Vytautas Magnus University in 1998, and new health psychology master programs were established in 2012 in Lithuanian Health Sciences and Vilnius Universities. Over the past ten years, the number of educated clinical and health psychologists in Lithuania has reached 500, with a total number of psychologists counted in the thousands. Strong, well-structured and accredited psychotherapy programs are run in the Lithuanian Health Sciences University and in Vilnius University, with independent programs and schools for humanistic, gestalt and other psychotherapies. There is a large number of professional organisations uniting psychologists and psychotherapists, with several conferences and workshops every year and an annual congress of the largest professional body – the Lithuanian Psychologists Association — which has large sections of clinical and health psychology. The Union of the Lithuanian Health Psychologists was established in 2001, actively collaborating with European Health Psychology Society, and focussing specifically on applying and integrating health psychology in the health care system.

This rich history of professionalisation of psychology in medicine is not reflected in the remuneration for psychology practice. The salaries in the governmental sector for psychologists are low, and sometimes comparable to non-qualified jobs in service sector. Many positions in state facilities remain unfilled. Psychologists often run private practices, where only the financial aspects are regulated by the state.

Until this year, psychologists working in the field of medicine and health care services had very limited regulation of their activities. The main defining characteristic of a "medical psychologist" was a masters degree obtained from a clinical or health psychology university program. The tasks that psychologists will fulfil vary depending on work descriptions from the respective health care employers.

Over twenty years ago, I was part of an ambitious "Consensus project" devoted to facilitating changes in the Lithuanian mental health care system. I chaired a working group for the assessment of accreditation and qualifications of the specialists delivering psychiatric services. The conclusion after assessing the legal situation, education requirements, and core competencies, was that well-defined and high standard qualification requirements are set only for psychiatrists and psychiatric nurses. There are no defined requirements for professional practice in health care for psychologists and social workers.

Ever since then, I and number of professional organizations have advocated regulating psychology practice and qualification requirements by the same legal instruments as are used in regulating medical doctors and nurses. A breakthrough came in 2018 when such a legal document – named "Medical norms of a psychologists in medicine" – was finally adopted by the Lithuanian Health Care Ministry. This is a step forward, but still of limited value since it sets too low qualification standards for clinical practice. Psychologists can join mental health care teams or be employed in any health care facility straight after university. A proposed supervised and accredited professional practice of at least 12 months (similar to residency for MDs), which is fairly standard in other European countries, as well as a licensing system has been rejected in the current version of the adopted document. That means that until today, many psychologists will encounter their first real patient on their first day at work. The current regulatory document is mired in another controversy, since it includes an unfortunate reference to treatment by psychologists.

These misunderstandings will hopefully be corrected. One day, Lithuanian psychologists in medicine may become more similar to Norway's highly competent, skilled, independent, and well-paid professional psychologists. ■

Balancing on the border of health and sickness – discussion of orthorexia in our health-oriented culture

Tiina Valkendorff

In contemporary western society healthy lifestyle and especially healthy eating are widely respected and encouraged. However, it has been discussed that some people may go too far or even obsess about healthy eating. Orthorexia is a term, which refers to this kind of obsession with proper or healthy eating.

The term orthorexia nervosa was first defined by American alternative health expert Steven Bratman in 1997. According to Bratman, orthorexia arises when a person is obsessed with a certain conception of health and eats only 'pure' and healthy foods in keeping with that conception. Orthorexia is not formally recognized in the DSM and there are controversial attitudes towards the term. It has been discussed whether orthorexia is a new type of eating disorder or a variation of anorexia or some form of obsessive-compulsive disorder.

As orthorexia is not officially defined, there is no exact information on its prevalence. It has been estimated that orthorexia is more common than other eating disorders. For example, the Eating Disorder Association of Finland regards orthorexia as one of the most common eating disorders. The concept of orthorexia has received only limited research attention. In recent years, however, orthorexia has drawn some scientific attention. For example, the PubMed search engine gives 107 results with the term orthorexia, most of them published during last four years.

Viewpoint in the article

Although orthorexia does not have formal diagnostic criteria and there is still lack of research, many lay people bring it up. In fact, the discussion of the topic has been active since the publishing of Bratman's article and definition of the concept. In media and in online forums it is constantly under discussion. My own interest is on how lay people discuss healthy eating and orthorexia, being part of my doctoral thesis in 2014. I included discussion of orthorexia nervosa on three Finnish online forums. What kind of information do lay people use when they talk of orthorexia on online forums? How is orthorexia addressed and defined?

Lay discussion of orthorexia in the Western "health-oriented culture"

Anorexia nervosa is the most well-known eating disorder and was put in focus after mid-20th century, as thinness was increasingly appreciated as a body ideal in Western countries. At the end of the century, discussion on how lifestyle impacts on health arose. Different kinds of health promotion flourished with advices and advertisements of how to live a healthy life.

Information about health effects of food grew along with views that you can eat yourself healthy but by eating you can also get ill. Discussion about lifestyle diseases or self-induced diseases emerged. Eating healthy food and a achieving a fit body became "signs" of good life. From a sociological point of view, eating healthy food can be seen as obeying health-based social norms. The causes of eating

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disorders are manifold. Cultural factors will influence food consumption and food choices, and they also form the background of discussion of orthorexia.

In online forum discussions of orthorexia many lay people mention its distinctive characteristics and the boundaries of normal eating. For some it may be hard to know what is healthy and when healthiness is taken too seriously. Where is the border between being healthy and too healthy?

"I'm near the border. But this is like a line drawn in water."

It has been stated that orthorexia may develop gradually, starting from an interest in a healthy lifestyle and ending up with strong fixation on healthy eating — damaging health instead of promoting it. Online fora often suggest that some of the afflicted suffer from symptoms similar to orthorexia. Writers may be aware that orthorexia is not an official diagnosis, but to them it is a real disease. Some ask for help.

"It's impossible for an orthorexic person to get help, because everybody else admires them and their eating and healthy lifestyle! No one cares, if it's an obsession!"

Healthy eating may have various meanings to different persons. Distinct from anorexia, people with orthorexia not necessarily focus on losing weight or get thin. They are not necessarily avoiding fat, but are rather interested of the type of fat. In orthorexia, focus is not on quantity but on quality. Some people with orthorexia focus on pure, natural, and unrefined food with no additives. Some may follow vegan, wheat-free, or milk-free diets. As orthorexia develops, the diet often gets ever more strict. In discussing orthorexia online, some lay people will question the idea of orthorexia as a disease, but some voices follow the view of official medicine and stay suspicious towards the phenomenon.

Despite the wide public discussion of orthorexia, the meaning of the term remains unclear. Some find it difficult to comprehend how healthy can be unhealthy. Unawareness of the term orthorexia and other eating disorders is probably one cause for suspicious attitudes.

Some voices on online fora have a critical attitude towards orthorexia because they feel they have healthy lifestyles and good eating habits, having nothing to do with disease. In online fora some writers are upset that others blame them as being orthorexic.

"Someone came to me to talk about orthorexia, although I'm just a normal athlete."

Conclusion

Overall, the online forum debates on orthorexia is diverse and far-ranging. It seems that online discussions can be divided into three different types of discourses. Orthorexia can be described in terms of a healthy diet, an eating disorder, and as a form of medicalisation.

The positions taken in these lay discussions on what is still a disputed term in the scientific community are also mixed: some voices in online forums accept the term orthorexia, others reject it, and others still remain doubtful.

As there is no official diagnosis of orthorexia, this lay discussion is interesting. Some express doubt towards the phenomena, and the concept of orthorexia can be viewed as a form of medicalisation. It is remarkable that many lay people contest the viewpoints of medical science. Orthorexia may not be medicalised by doctors, but it may be strongly so by lay experts. ■

Psychiatric encounters in Ivalo, northern Lapland of Finland

Lumikukka Socada

An appointment begins. I say: "I come here every two or three months, I work here for two days, have maybe one day free and go hiking in the fells. Then I fly back south". The most important information for a new patient is the last part of my beginning sentences: I come and I go, I am visiting for work. Many patients have never told anybody about tragic events of their childhood, of their depression, obsessive thoughts or anxieties, because they are here often regarded as a taboo. For me they can tell, because I go with the information with me; I am not part of their everyday life, in the village of Ivalo where I meet them, with its approximately 3050 inhabitants, or in far smaller villages scattered in the wilderness, with a few hundred to less than 30 inhabitants.

I fly to the northernmost Lapland of Finland, to Ivalo village, to arrange psychiatric consultation appointments for the local occupational health care provider in the municipalities of Inari and Utsjoki. In this region of 22 700 km2 there are 8100 inhabitants, the population density being 0.40 people per land sq. km. In Inari commune four official languages are spoken, three of them by indigenous people of Finland, the Sámi (Sámit or Sápmelaš).

Everybody in the North have a story to tell — a story of why they live here. It seems that nobody is here by coincidence or without a reason. I realize, I almost never ask my patients in Helsinki, why they live there, why there and not elsewhere: "What keeps you in Helsinki?" No, I don't ask that. But here in Ivalo it is a crucial part of the identity of the people, both Sámi people and other, most of them Finnish, some foreigners from Central or Southern Europe. Many are born in Lapland; their families may have lived there for generations. Still for them, when they are young or were once young, it is or was a conscious decision: to go or to stay. Some say, all their friends have moved south. Another group are the people who came from elsewhere. Some for love, some because of the wilderness, some for work. Some stayed for life, some are dreaming of

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moving away already after few months. Some came because of problems they encountered in the South and come to see me wondering, why the same problems seem to be here in the North, some realizing, that they brought them with them.

Approximately one in five of my patients are Sámi. Some are younger struggling with questions whether to stay and live the traditional life with reindeers, to preserve the culture, or to go and follow some other dream. They may encounter pressure to stay, for so many have left. Some are older, some belong to the generation which experienced Finns oppressing Sámi people, forcing children away from their families, to live in boarding schools, where it was forbidden to talk any Sámi language.

There are three different languages and cultures of Sámi in Inari: Northern Sámi, Inari Sámi and Skolt Sámi (the languages differ so that speakers cannot understand each other, unless they have studied the other language). Inari Sámi is spoken indigenously nowhere else in the World except in Inari. It has happened, that a child who spoke for example Skolt Sámi was forced in a boarding school, were all other children spoke Northern Sami and teachers Finnish. All kinds of atrocities have happened in the middle of the 20th century, when the boarding schools built for Sámi children existed. Almost an entire generation had to give up their mother tongue. Some of these people come to me and explain what happened decades ago, some speak for the first time. It is possible for these people to get psychotherapy, thanks to internet and Skype, in Finnish language from anywhere in Finland – there is one psychotherapist in Ivalo – and in Northern Sámi language from Norway (there are no Sámi speaking psychotherapists in Finland – yet), thanks to a special agreement between Finland and Norway.

Nowadays the atmosphere is full of hope, grandchildren of Sámi speakers are regaining the language of their ancestors in kindergartens, and schools have basic education classes 1-6 in Inari and Northern Sámi languages, also some teaching in Skolt Sámi. Sámi people have their own representative political body, the Sámi Parliament (Sámediggi, Sämetigge, Sää'mte'gg), situated in Inari. The distribution of money creates tension, a lot of money and time would be needed to run the kindergartens properly and to develop material in Sámi languages for teaching. Not everybody agrees

The library of Ivalo, "library" written in the four official languages of the municipality: Finnish, Northern Sámi, Skolt Sámi and Inari Sámi.

who and what is "Sámi enough", what is the right definition of this culture. Not every Sámi family have ever had reindeers, some have fished. Some people are devoting their free time and entire life for rescuing Inari Sámi language and culture, and others refer to it as a dying language, I have heard these discussions with my own ears. Yet people, with Sámi or other origins, live in the small communities together and have an amazing ability to continue to work and live together, despite disagreements. Partly because there is no other work available within hundreds of kilometres.

The stigma of having a mental disorder is strong in the North in distinction from the South of Finland. Patients do not want others to know if they are depressed or have a bipolar disorder. They may end up lonely, because even family members do not know. Some are terrified when I suggest psycho-educational reading from an internet site with a heading "Mental health". Several times an employer has implied, if somebody has a sick leave because of e.g. depression, that she/he isn't welcome back to work, because this person is not trustworthy anymore. It is like it was decades ago in more densely populated areas in the South. These attitudes can be fought with accurate information about mental disorders and their prognosis, with written attests for people, so that they can continue their studies or work.

For many people, Northern Lapland is unique in giving life and living a purpose as a member of a community, as somebody reviving a language and culture, and as a place to find quietness and peace in nature. From small communities and traditional ways, as well as from the past historical oppression and confrontation still echoing today, rise problems that can and need to be solved, one at a time. I find my work in the North meaningful with all its challenges. ■

The future psychiatrist is international – crossing borders in exchange!

Aistė Lengvenytė

Being a trainee in psychiatry is a constant challenge. With an overwhelming neuroscience, the ever-changing disease and treatment paradigms together with huge mental healthcare systems differences worldwide, it is easy to get frustrated and close oneself in a sealed educational compartment, not letting other intercultural components affect your progress. During globalization, understanding other cultures and mental healthcare systems becomes increasingly important. First, it is all very pragmatic, as no one of us will escape the challenges of dealing with people from different backgrounds. Second, it is also crucial for the very basic theory of psychiatry, which must incorporate knowledge of our own nature as cultural beings with individual and collective histories.

Aistė Lengvenytė Psychiatric trainee in Vilnius University, Lithuania and Montpellier University, France

I was a great fan of complexity even before starting my training in psychiatry. I knew that I had to try to grasp how the collective mind works before I could ever try to understand how individual human minds do. After practice and study exchanges in three different countries during my medical studies, I just could not miss the opportunity to exchange ideas with people from different backgrounds during my training.

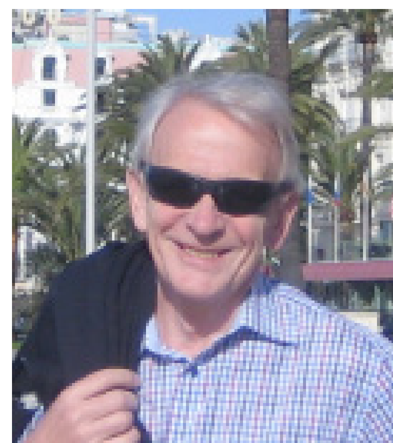
So, I was more than happy to find out about the European Federation of Psychiatric Trainees (EFPT) and its exchange programme. The EFPT represents trainees from 37 countries. Various working groups of the organization address questions relevant for psychiatric trainees. After the first year of residency, I participated in my first EFPT forum in Istanbul, taking part in an exchange working group, learning about the platform created by trainees for trainees. The exchange programme was established in 2011 during an annual EFPT forum, and in 2012 the first trainees went on exchange to seven different countries. It has been expanding ever since, and in 2018 it offers 64 placement opportunities in 16 European countries. The placements are free of charge, last from 2 to 6 weeks, and the application period is open twice a year. More than 200 trainees have gone on exchange through this programme and more than 90% indicated that they were very satisfied with the experience and would recommend it to their colleagues. On a personal note, the fact that the programme flourishes despite its being fully based on voluntary premises reflects the young psychiatrists' eagerness to communicate and cooperate despite differences.

After one more year I write this text on a train in France, traveling from the French Psychiatric trainees' congress back to my temporary home in Montpellier, France. I did not go on an EFPT exchange yet. Instead I used another opportunity, available for all trainees in Lithuania – Erasmus practice in another European Union country's hospital. Thanks to the Erasmus programme, as well as my home and host universities and the kindness of French psychiatrists, I am on a one-year placement in Montpellier, where I participate in clinical, teaching and research activities. Is it different? A lot. There are many differences from Lithuania in the way medical exams are taken, the treatment schemes, and the legal system. This makes me reflect that there are many ways of thinking and handling similar situations. Is it hard? Adjusting to a completely new system in a different language never promised to be easy. So is it worth it? Definitely. Different cultural influences, teaching and clinical practices raise so many questions. I believe some of them will turn out to be the right ones.

More information: www.efpt.eu and www.erasmus-programme.com ■

Do no harm!

Högni Óskarsson



The #MeToo movement became a surge in 2017, a revolution by some accounts. Initially it focused on the entertainment industry, but spread to other areas of society. Healthcare, inside and outside hospitals, is not exempted. Despite the increasing role of women in healthcare, the industry still has an image of being dominated by men and paternalism. So it comes as no surprise that accusations of sexual transgressions have come up, involving male doctors mostly. Studies have shown that psychiatrists have been up to four times more likely than in other specialities to be accused by patients of sexual assault.

Högni Óskarsson is a psychiatrist in private practice in Reykjavík. In addition, he coaches leaders in the community, and is a crisis management consultant. He has been leader of a nation-wide suicide prevention program in Iceland, chairman of the WPA Section of Quality Assurance in the nineties and a consultant to Decode Genetics.

Why? Selection of sexual predators into psychiatry? No. Something in the work environment? More likely. Our patients come to us with a variety of problems, most with damaged self-esteem, vulnerability in interpersonal contacts, and in need of someone to trust. Our contacts with patients are mostly one-on-one. Consequently, the boundaries must be very clear, to ourselves as professionals, and to the patients as well. The underpinning of the doctor-patient is trust, and again trust.

We don't often think about our professional boundaries at work, we take them for granted. The boundaries relate to the way we behave in our role as doctors, the image we create by appearances and expression, how we define our private space in terms limited self-disclosure and physical contact. This does not imply being cold, rigid and without empathy. On the contrary. But the relationship is based on professionalism, not friendship. Thus, it is important to set limits on non-acute contacts outside office hours, casual encounters outside the office setting should be avoided, as well as discussing our own private lives with patients. This has become increasingly difficult in to-day's social media culture, and calls for even more circumspection on our part.

So what is the big deal? What may start as a minor infraction has a tendency to grow, possibly escalate into a serious breach of trust, harming the patient, the doctor as well, even our standing as a profession. Serious infractions happen rarely, though. It is important to keep in mind that doctors who get into trouble have a tendency to confuse their personal with their professonal life. Furthermore, those who transgress are quite often under duress, be it recent trauma, personal or work stress/burnout, and/or problems with alcohol or drugs. Needless to say, we have to be alert to our state of mind and emotions, and seek help instead of acting out.

All sexual contacts, from innuendos, inappropriate touching to intercourse, even consensual, are out. Some say for a lifetime. A patient's consent is always invalid. The power balance in the relationship is skewed in favour of the doctor. There are always transference/countertransference issues at play, that have to be respected and worked out. Overstepping boundaries is a breach of trust. The patient's treatment is damaged; the problems brought to treatment may become more severe, even to the brink of suicide. Trust in other professionals may be damaged. Harm is done.

We as psychiatrists have to remind ourselves, that we are not an extra-special brand of human beings, infallible and untouchable. We have to be responsible to ourselves, to colleagues who may be at risk, and to make our workplaces more humane, as prevention against undue stress and burnout. ■

Doctors and social media

Þórgunnur Ársælsdóttir

Social media is a term for any online communication channel that allows the user to find and interact with a community. Facebook is the largest of them all with over two billion users. Social media has only recently become an integral part of our everyday lives, and most of us have been navigating this new online territory feeling quite unsure how to tread. Some avoid it as long as they can, for different reasons, and some like it so much that it overtakes other aspects of their lives. We have all seen different and new kinds behaviour in these online communities. Some behave in an attention-seeking manner, posting comments and pictures, often of themselves, several times a day. Others are more reserved, posting or commenting rarely if at all, or hardly ever opening these sites.

Thorgunnur Arsaelsdottir is a former president of the Icelandic psychiatric association, and currently head of the psychiatric emergency department in Landspítalinn university hospital in Reykjavík.

Observing peoples' online behaviour is interesting, especially from a psychological perspective. Already some studies in psychology are based on subjects' use of social media sites, which is no surprise. As is currently being discussed, these huge global networks are accumulating gigantic amounts of data about our behaviour. In a brave new world of artificial intelligence, this is valuable information.

So what is the correct way to behave on social media, as an individual, and as a doctor? Can you ever be only one individual or are you always also a psychiatrist? Is it appropriate to have patients as friends or followers on social media? Are personal and professional boundaries in danger if your patients see pictures of you and your family, read your comments and views on politics, or are informed about your recent romantic weekend in Paris? Can you post pictures of yourself in the gym, or a selfie wearing a bikini at the beach if you also want to be a respectable medical professional?

Some of these questions seem fairly easy to answer, others are not as simple. I think it is a good idea to decide on some general rules to stick to. The first and most important rule is not to say or reveal anything on social media that you would not be happy to see printed in a newspaper, for all to see. Ethical and legal standards apply to us also online, and if you use social media to post medical issues, or blog about your work life, then ethical and professional standards apply even stronger. Some doctors who do so have separate sites for their professional online persona and another for their private one.

In general, it is not wise to accept friendship requests or online following from patients. If I get a request from a patient, I thank them when I see them next time in person and explain that I would have liked to make that connection, but for ethical reasons I cannot since I am the doctor. Most often people find that easy to understand. Of course, this does not always work out perfectly. For example, you may be connected online with a friend or a relative of a patient, especially in a small community like what we have in Iceland. A third general and good rule is to manage your privacy settings so that your online content is not visible to all.

Our profession is a large part of our lives. We are trained to help and respect people and setting clear boundaries is a cornerstone on that journey. These boundaries are needed for the trust and privilege given to us in our work, both on- and off-line. ■

'Techorexia' - the dark side of fitness gadgets and gizmos

Ragnhildur Thordardottir

**The iTunes store features thousands of "Health & Fitness" apps.
MyFitnessPal calculating calories, heart rate monitors, and weight-loss gizmos like Fitbit counting daily steps. For most people, these new apps and technologies are useful tools for self-improvement through exercise and healthy eating.
At first it can provide a structure and induce feelings of security to write down everything you've eaten and tracking every step. But it can soon turn into a perverse game of arithmetic where people become slaves to the numbers.**

Step counts, calorie limits, number of pounds lost per week.

People can go to extremes to meet numerical goals, and become really upset with themselves if they aren't met.

The term "Techorexia" describes the numbers-driven compulsive behavior of logging every morsel of food in an app, and tracking every calorie burned.

This behavior supposed to make you healthier can quickly spiral into a negative control issue reinforcing unhealthy obsessions.

Fitness trackers have a dark side that can trigger disordered relationship with food and training by tweaking the inputted data to see how to lose weight quickest by eating food with the fewest calories.

The nature of these apps and gadgets therefore speak to the very core pathology of obsessive thinking and compulsive behavior: "If I do this, then I have to do that."

"If I eat X calories, I have to exercise for Y minutes."

Deviation from daily calorie allowance or physical activity goals can fuel feelings of anxiety and guilt. People start to have a spreadsheet-like relationship with their intake and amount of exercise. Instead of looking at the body from the inside out, they look at the body's needs from the outside in.

WHEN, WHAT AND HOW MUCH to eat and train

Outer factors of apps and trackers that dictate **When, What** and **How much** to eat and exercise can lead to a lack of mindfulness and disconnect from bodily signals.

When to eat is according to the app instead of paying

Ragnhildur Thordardottir
Psychologist, M.Sc Health Psychology
Cand. Psych Clinical Psychology

I'm a health psychologist, writer and a published author. I've written articles and books on training and diet for 14 years.
I'm a psychologist with a speciality in helping people developing healthier relationship with food and exercise through cognitive behavioral therapy with emphasis on behaviour modification, development of health habits and a mindful eating approach.
I'm also a dedicated CrossFitter and weightlifting enthusiast with a passion for exercising and honoring my body.

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I'm also a dedicated CrossFitter and weightlifting enthusiast with a passion for exercising and honoring my body. attention and recognizing hunger signals. This can often lead to not eating when hungry, and eating when not hungry.

When to exercise. Activity trackers don't account for rest days and training when tired and fatigued can exceed bodily limits resulting in exhaustion or injury.

What to eat is according to a safe list of low-calorie foods.

This can feed the Dichotomous and inflexible thinking of "good food" vs. "bad food" where the list of "good" foods shrinks rapidly because every calorie counts and the app tells you which foods contain the least amount.

"I didn't know mackerel was so calorie dense. I'll just stick to white fish to not go over my daily allowance."

This type of thinking can exacerbate disordered eating and anorexic behavior where eating less than "allowed" daily calories is rewarded through better weight loss profile.

This can wreak havoc on people's health by missing out on essential nutrients like dietary fats.

Furthermore, a day over the calorie goal becomes an excuse to binge until the next day, when the restricted hunger games start again feeding the 'all-or-nothing' mindset towards eating.

"I have already blown it today, I might as well stuff my face and start with a clean slate tomorrow."

How much to eat is based on grams of food and calorie content to decide the amount of food on the plate instead of paying attention to the internal signals of fullness when Leptin the satiety hormone is released in the body.

This approach people miss out on learning how different food and meal patterns affect their fullness.

How much to exercise.

When app users go "over" their allotted calories the minutes of exercise to make it up is recommended. This compensation of out-training diet is a slippery slope towards eating disorders.

Trying to reach and even beat the generic 10.000 steps a day or going over recommended max. heart rate can become an obsession, and excessive exercise can result in overtraining and burnout from working out.

Pant size instead of wellbeing, skinny instead of healthy

Fitness apps and trackers might promote healthy eating and exercise as appearance driven instead of health reasons as exercising for health need not be excessive.

From a health and longevity standpoint healthy eating is about nourishing your body, and exercising to honor your body's needs.

Appearance driven motivation is extrinsic and short-term.

Health driven motivation is intrinsic and long-term.

Fitness apps, gadgets and gizmos are not a menace to society but if the thought of not counting steps in your morning run or logging teaspoons of salad dressing for lunch is causing anxiety, that's a huge indicator that it's not a healthy relationship.

Wellbeing and health shouldn't be a numbers game. ■

Highlights from the Nordic Journal of Psychiatry

Martin Balslev Jørgensen

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

Providing ECT? Please don't rush!

IThe authors investigated the effect of delaying initiation of electroconvulsive therapy (ECT) after administration of anaesthetic agent and muscle relaxant in a retrospective cohort study utilizing a case-based analysis comparing number of re-stimulations, length of seizures, number of ECTs per series and stimulation dosage before and after introducing a new treatment regimen. In 2013, ECT was initiated approximately 60–90 seconds after administration of thiopental and succinylcholine. This interval was increased to 120 seconds in 2014. They showed that a lowered frequency of re-stimulation was independently associated with the 2014 treatment regimen. The study substantially strengthens the evidence on the benefits of delaying ECT after administration of anaesthetic agent and muscle relaxant.

Asztalos M, Matzen P, Licht RW, Hessellund KB, Sartorius A, Nielsen RE. Delaying initiation of electroconvulsive treatment after administration of the anaesthetic agent and muscle relaxant reduces the necessity of re-stimulation. *Nordic J Psychiatry 2018. 72:5:341-346* |

Patients with higher social desirability responds rapidly

Still, treatment efficacy of SSRI's varies significantly from patient to patient and about 40% of patients do not respond to initial treatment. This study aimed at identifying specific personality traits that could be predictive of treatment response. In a sample of 132 outpatients with major depressive disorder (MDD) escitalopram, the Swedish universities Scales of Personality (SSP) were used to find predictive personality traits. Escitalopram-treated MDD patients with higher social desirability achieved more rapid decrease in symptom severity. The findings suggest that specific personality traits may predict the trajectory of symptom change rather than the overall improvement rate.

Aluoja A, Tõru I, Raag M, Eller T, Võhma U, Maron E. Personality traits and escitalopram treatment outcome in major depression. *Nordic J Psychiatry 2018. 72:5:354-360*

Patient reported outcome measures in psychotherapy of anxiety and depression

Patient-reported outcome measures (PROMs) for anxiety and depressive disorders are an important aspect of measurement-based care. This study performed a clinimetric analysis of two PROMs scales in patents with depression and anxiety. Patients completed a 10-item version (SCL-10) of the Symptom Checklist to measure burden of symptoms and a brief 5-item version of World Health Organization Well-being scale (WHO-5) to measure quality of life. Results: A total of 801 patients were recruited from two Danish mental health centers with anxiety or depression. The standardization of the SCL-10 and WHO-5 by T-scores indicated that a T-score of 65 corresponding to being moderately in need of treatment and a T-score of 75 to be severely in need of treatment. The study supports the use of the SCL-10 and WHO-5 as potential PROMs to capture symptom burden and quality of life within groups of people with anxiety or depression undergoing psychotherapy treatment.

Bech P, Austin SF, Lau ME. Patient reported outcome measures (PROMs): examination of the psychometric properties of two measures for burden of symptoms and quality of life in patients with depression or anxiety. *Nordic J Psychiatry 2018. 72:4:251-258*

Antidepressant prior to exposure therapy for anxiety?

The authors aimed to identify patients' characteristics associated with a differential course of fear during symptom provocation and to elucidate the effect of selective serotonin-(noradrenalin-) reuptake inhibitors [SS(N)RI] on development of fear in the context of re-exposure to the phobic stimuli. Patients with panic disorder and agoraphobia (PD/AG) were classified into subjects who show a reduction of fear ('Fear–') during a symptom provocation via a picture-based paradigm (T1) and those who did not ('Fear+'). Subsequently, SS(N)RI treatment was administered to all patients and subjects were re-exposed to the feared stimuli after 8 weeks of treatment (T2). Brain activity within the 'fear network' was measured via functional magnetic resonance imaging. Fear – were significantly younger and demonstrated increased exposure-related fear as well as stronger activity in several fear-related brain areas than Fear+. There were improvements in all clinical parameters after pharmacological intervention for the whole sample. However, reduction of fear as well as activation in (para)limbic structures during symptom provocation were now attenuated in Fear – but increased in Fear+. The authors conclude that the was no negative impact of medication on fear development at all and that there was some evidence that SS(N)RI treatment might improve the individual ability to get involved with the agoraphobic stimuli while conducting disorder-specific exposure.

Plag J, Petzold MB, Gechter J, Liebscher C, Ströhle A. Patients' characteristics and their influence on course of fear during agoraphobic symptom provocation: may SS(N)RI treatment compensate unfavorable individual preconditions? *Nordic J Psychiatry. 2018:72:5:325-335*