THE NORDIC PSYCHIATRIST

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Psychiatry and the arts

NORDIC PSYCHIATRIC ASSOCIATIONS

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The Editorial Board
Front row: Marianne Kastrup, Hanna Tytärniemi, Ramunė Mazaliauskienė
Back row: Ola Marstein, Hans-Peter Mofors, Óttar Gudmundsson

Dear colleague,

I caught the "opera bug" early on as a teenager. I do not know how and why that happened, but something about opera spoke to me and captured my young imagination. Since then I have been hopelessly devoted to this form of musical theater. Situations in daily life can suddenly conjure in my mind the scenic and musical accompaniments of its operatic equivalent. Indeed, life inspires art and its greatest celebration according to me is in the art form of opera. When I visit the opera house, it is very striking to notice the number of psychiatrists one meets, as compared to colleagues from other medical specialties. How can that be?

Art is essential to life. Be it music, dance, theater or literature - art gives us the possibility to work through our emotions. Art can be a means of catharsis, help us to better understand our thoughts and feelings and equip us to better navigate the ups and downs of life.

The cultural expression of art is most often emotional in character. We can experience joy, pain, longing, hate, fear and all the other emotions in the human psyche through art.

Psychological suffering occurs when these emotions are amplified and get out of control.

The sometimes over exaggerated expression of these emotions in art forms like opera allow us to experience the extreme highs and lows of the human psyche in a controlled and beautiful form. Perhaps this is what makes it so irresistible to us psychiatrists.

In this issue of The Nordic Psychiatrist we want to discuss psychiatry and art. How has psychological suffering and psychiatric disease been portrayed in the arts? Who are the persons behind the works and can we describe or diagnose their possible psychiatric illnesses? The possibilities are endless but we have tried to identify a few exciting topics.

Hans-Peter Mofors

Art and culture has been historically used as a means to treat psychiatric illness but of late has been used infrequently due to lack of evidence and financing. Have we thrown out the baby with the bathwater? You will read about "forgotten" forms of psychiatric treatments.

Many psychiatrists are also active expressing themselves in music, literature or art – on a private basis or connected to their professional work. You will read quite interesting and different stories.

As always you will also find interesting and articles and commentaries on psychiatric research, education and history. We also get to experience a week in the daily life of a psychiatrist, north of the polar circle during winter

I wish you happy reading.

Best wishes,

Hans-Peter Mofors,
Editor

Psychiatry in the time of Corona

Ulrik Fredrik Malt,
President of the Nordic Psychiatric Associations

The lock down of social interaction in many countries due to the SARS-Cov-2 epidemic has several psychological and psychiatric implications. E.g. anxiety of becoming ill, social isolation and depression, exaggerated anxiety in patients with severe agoraphobia and fear of being left alone, and not the least delay in seeking professional help for mental disorders. Some of those consequences can be dealt with by telemedicine. However, patients with chronic mental disorders, e.g. schizophrenia, severe OCD, bipolar disorders, and anorexia nervosa, requires face-to-face contact and knowledge about somatic and treatment implications of stress on the mental disorder. After all, there is no evidence that internet-based therapies will help the most severely ill.

Furthermore, if CoV-19 (infection) occurs, the mental health care system must cope with several other implications. Patients with severe mental disorders have an increased risk of dying if they suffer from CoV-19. There is an increased risk of cardiac arrhythmia in patients with CoV-19. This may imply reduction in dosage of antipsychotics known to increase the risk of arrythmia in high dosages, such as amisulpiride, sertindole, ziprasidone, risperidone, olanzapine, and quetiapine. Drugs used off-label to treat CoV-19, such as chloroquine and hydroxycholorquine, may provoke severe mental disorders like psychosis and suicidality. Hypoxia and acute respiratory distress may sometimes require additional psychiatric interventions.

Adding to potential challenges, are colleagues developing insomnia and anxiety which in some cases have progressed to panic or resignation, demoralization, and depression as reported by Italian psychiatrist.

All the challenges and clinical issues listed above, require good knowledge of both psychiatry and somatic medicine, reemphasizing a pivotal role of psychiatry in pandemics. ■

Ulrik Fredrik Malt
Emeritus Professor of Psychiatry and Psychosomatic Medicine, Institute of Clinical Medicine, Faculty of Medicine, University of Oslo, Norway. President of the Nordic Psychiatric Associations

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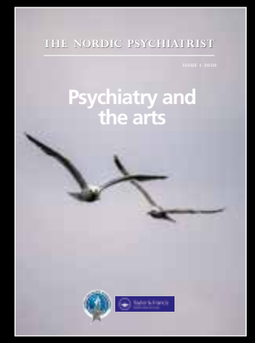

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How Art and Music Affects Us?

Interview with professional musician and professor of social psychiatry Sami Pirkola

Hanna Tytärniemi

Sami Pirkola is a professor of social psychiatry in Tampere university. His main research interests are mental health care services, psychiatric epidemiology and suicidology. He is also a professional musician in a Finnish rock band called "Juliet Jonesin sydän". The band was among the most popular Finnish rock bands in the 1980's and 1990's. After a pause of 15 years the group returned on stage in 2015 and they have just released their latest album "Kansas" in 2020. This interview discusses the general effects of art and music from individual and social point of view.

How do you combine life as a professional in psychiatry and a professional musician?

These two roles are quite distinct from each other. For instance, I have never done scientific research about relations of psychiatry and music. I am a psychiatrist and a musician from passion for both areas likewise. Music thrives me and has always been an active and important component in my life. I play the guitar every day. Composing takes place naturally little by little and is a creative process that also measures my own well-being. If I am not creating music, it usually indicates something being wrong with myself.

What kind of correlations do you see between psychiatry and art?

Psychiatry and art are both interested at similar phenomena from different angles. They both examine and interpret the subjective experiences, consciousness and extreme mental states. Art questions our values, challenges the obvious and criticizes defects. Sometimes this is moderate, but some artists are very straight-forward and truly challenging us with their insights to intensive emotions and life experiences. Art provokes us to study our minds and adds understanding and mental well-being by doing so.

What do you think about using art as a healing element in psychiatry?

Obviously art and music have a great therapeutic potential, and this has been shown in both psychiatric and neurologic rehabilitation. On the other hand, creating art deliberately for psychiatric use may pose restrictions in the artistic expression. Art at its best has been formed from a need to create and to ventilate the artist's emotions. In order to mediate healing elements, art should be unexpected and evoke unexpected feelings. I think patients should have equal rights to experience art. In that perspective I support presence of art in psychiatric hospitals and other institutions.

How music affects us?

Music is known to thrill our brain in incredibly versatile ways. Listening to or creating music often involves free association, emotional processing, pleasure reactions, memories, motor activity etc. Therefore, several brain areas are activated in processing of music information, for instance auditory, sensory and motor cortex areas, amygdala, hippocampus, prefrontal cortex and cerebellum.

I think music offers a great channel to activate our brain in different ways from the usual activities. For instance, music may help to focus at work. I listen to certain kind of music while I work, and this improves my work quality. For others, simultaneous music may intrude concentration too much. But even then, music may provide a chance to ventilate the brain in between concentrating to work or stressful issues.

Sami Pirkola
MD, PhD, Professor of Social Psychiatry, Tampere university, Health Sciences and Vice-dean research for the Faculty of Social Sciences. A professional musician, guitarist and composer in a Finnish rock band "Juliet Jonesin sydän" ("The Heart of Juliet Jones").
Photo by Pasi Rytkönen

We all experience music differently. Others may concentrate to details or certain instruments while others simply go with the flow and sense the general impression. What do you think about individual interpretations of music?

Experiencing music could be compared to how some people experience nature, culture or sports. Experiencing music is not a purchase or a task to fulfill but rather something that takes place naturally. On the other hand, artistic experience is very personal, but music also enables sharing of mutual feelings. This may result at better understanding of oneself and others. There are also some automated or learned responses as well. For example, in Western music we have learned to associate certain patterns, tones, chord combinations and melodies with certain emotional contents and lyrics.

Most of us have emotional memories from our earlier phases, for instance early romantic relationships or separations, that are closely related to and activated by certain songs or music styles. This is a typical example of how music activates our thoughts and feelings individually but also enables sharing them with others.

What do you think about music and community?

Music connects people naturally in many ways. We can all communicate and share our individual insights about music. For myself, it is fairly easy to relate with other "music maniacs" and this often generates a sensation of unity and feels like our brain are tuning similarly. Music has a strong power to unite people.

The current Coronavirus pandemic affects us all. I have personally noticed an enormous increase in my listening of music at home. How do you perceive the role of music in this situation?

We can see how important community is during social isolation and critical times. It is interesting and heartwarming to notice how music plays a role in strengthening this community feeling, for example neighbors singing and playing together from their balconies or applauding to health care professionals. I appreciate how several musicians have shared their clips of music in the social media and live stream gigs are released. In general, people are now more open and sharing more intimate feelings in social media. Even remote work from home is bringing our private lives and public lives closer. The crisis situation seems to revive social communal activity in general. I hope this continues somehow even after the pandemic crisis. Let's keep the spirit up! ■

The use of Expressive Art in my psychiatric practice during 40 years

Svante Bäck

The word *psychiatry* comes from the Greek word *psyckhe`* that means soul and *iatreia* that means cure. We don't know exactly what the soul is or where it lives but we guess it's in the brain itself. And we do want to cure it when needed. Today we can look into the working brain with MR but we just are in the start of understanding how it works. Another way of looking "into" the brain is to use different form of Arts and Expressive Art therapy. Here we meet fantasy, dreams, feelings and hallucinations. Without making the detour with words. As a photographer I am interested in art and how to make a picture that grabs hold of you. I play the flute, and also the recorder (blockflöjt). So I like to use expressive art in psychiatry, as often as I can. Here are some of my thoughts and experiences of using expressive art through the years.

1. MUSIC

A.

One day I was supposed to meet a man in his 30-ies to decide whether he should remain committed in our ward. He was from Russia and only spoke a few words of English. He looked and smelled dirty and I was to decide whether he was psychotic or not. He mentioned that he used to sing songs in the street to get some money.

- Are you good, I asked?
- Yes he answered without hesitation.

We had just got a guitar placed on a hook at the wall. The room was also used for ward-meetings. I handed it over to him saying:

- Play a song.

And so he did. He sung the Old Russian lyrics with a dark expressive voice. Many verses.

I accomplished him for this, and added: - Yes you are really good.

From that moment we could talk in a much better way. He was a very special man, but not psychotic. He promised to stay freely if he now and then could use our guitar.

So we had a deal.

B.

I consider music to be a language, often better understood than our usual languages. It also has the power to change our inner mood if you are feeling tense. So:

Svante Bäck
Psychiatrist, Västervik Sweden.
About Svante Bäck:
I´ve been working as a psychiatrist for more than 40 years in Västervik Sweden. It´s a small town on the east coast that used to have a big mental hospital for a big region. It was built in 1912; in 2000 the last part of it was closed and the Open Care units and the Psychiatric clinic at the somatic hospital area had to manage the job needed. For many years I was head of this psychiatry, but also a working psychiatrist at the same time.
Today, at the age of 71, I still work a little bit as Rent-a Doctor, but not in Västervik. Of course I play on my flutes, take a lot of photos and I also do some writing about Psychiatry.

We had a meeting Monday to Friday for the doctors, junior and senior, at 8 o clock. At least for 30 minutes.

The doctors that had been on duty reported the different patients they had met.

I opened the meeting at 8 ò clock with an improvisation on flute and reading a poem. The best poems were modern ones that made you reflect. After some words over the poem we approached our daily tasks for instance the report from our doctors who had been at duty during the night.

Our climate of the meetings got better and better. When someone dared to tell about the dark themes like suicide, feeling small and helpless without feeling ashamed I felt proud over our group.

We also had a very strict rule for everyone to accept:

Praise in the big group—but criticism between four eyes.

That meant that if you thought something should have been handled in another way, one of the senior doctors said:

-Let's have a few words after the meeting you and me.

2. PICTURE

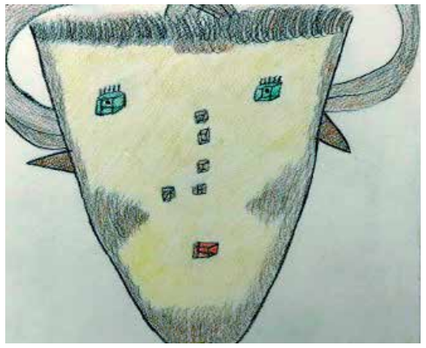
A.

Some years ago, one male patient about 45, gave this picture to his open care unit. He had been seeing a social worker here for some time. This was an unexpected gift that did not seem to be linked to what the patient had been discussing at all. He had no other comments than – Thank you for your help. It was stored, and was found many years later when the man was arrested for two murders of young women. He was later sentenced to forensic treatment and spent some years at our ward. After a few years, he committed suicide; he never confessed what he had done. He always repeated that he was innocent. Although

the evidence was quite conclusive.
I think we can see a young naked girl, maybe her hands are strapped. It gives me a feeling of torture.

If you look at the picture with this in mind, was it a start of a confession that was never fulfilled?

B.
For many years I had a highly educated painter Amar Dawod who is originally from Bagdad, working with patients. He was not a therapist, but indeed he made many therapeutical things. Amar inspired the patients to expressing themselves in art.



The patients, who mainly were at our forensic departments, applied freely to work with him. Some made fantastic pictures, here a woman who made a cubistic self-portrait. It is really a unique way of making a portrait, and so expressive isn't it?

A male forensic patient made this painting of a female torso. He had been psychotic newly but was now much better. He was not a sexual offender.

As you can guess he had an artistic education.

C.

One day, Amar Dawod had looked into our room for restriction. He said to me

- It must be terrible lying there in fixation for hours just looking at the boring ceiling. I want to do a Mandela drawing there instead.

- Ok, I said and here you can see the new view a week later.

Mandela In Sanskrit means *circle* and it is a symbol both

in Hinduism and Buddhism. It symbolizes the idea that:

Life is never ending and everything is connected.

The Mandela also represents a spiritual journey within the viewer.

Our Mandela has been highly appreciated of our patients who involuntarily have spent some time in this room.

D.
When meeting new patients you want to see their different sides, not only the illness. It is the person that`s suffering from something, the illness has no own life.

So I started trying a method mainly used for children. It`s called"Draw a Man". And I found that it worked fine also with my grownups.

I am often seeing patients for the first time for estimating the sort and grade of illness. At the end of the session I sometimes say:

- I have an odd request, I would like you to draw a man (människa) on this sheet of paper.

- You are completely free to draw this any way you like.
- OK, I'll try…..

This is a drawing of a Schizophrenic woman in her 40ies. She had no own comments. She had been ill for

maybe 25 years.

I think it is a very personal" self-portrait", it even shows how her body is falling apart. Many schizophrenics not only have a split self, but also have lost control of their bodies as you can see here.

Here is another example:

This young man is drawing himself and his dog. He longs for a girlfriend and has made a place in the drawing for her. It was a happy young man with a severe ADHD, but very lonely.

3. Clowns

One day a man phoned and asked me for someone on BUP (the child psychiatry). He was a clown and worked with his clown colleague in Child Medicine wards in Kalmar. I quickly told him to come to our psychiatric clinic instead in Västervik. – But is it possible to have clowns there he asked worriedly.

– Absolutely, I answered. And I was right.

During a year and a half we regularly had two clowns coming to all our 5 wards including forensic psychiatry. It was a success. Most of the patients attended all the 30 minutes of the show at each ward. Since some of our patients "live" in their wards for many ears it is important so give them a living milieu. Where a daily laughter is a good help. Charlie Chaplin said: *A day without laughter is a day wasted.* And that goes for all of us!

DISCUSSION

We know that there is a genetic linkage between leadership, being artistic and our big psychiatric illnesses Schizophrenia and Bipolar disorder. So one can expect that some of our patients are good at expressing themselves in expressive arts. We also know that some of our most important painters have been at mental hospitals for instance Carl Fredrik Hill and Ernst Josephson. Not to mention Erland Cullberg, who during his lifetime had an own exhibition at the Moderna Museet in Stockholm.

I think that our psychiatric treatments today tend to forget the right hemisphere in our brain, where creativity and feelings are mainly located. We focus too much on left hemisphere questions; logic, language etc. We do need ways to meet patients who are much better in using their right hemisphere and who are not so good at describing their world with words.

We also know that if we are frightened and angry, we tend to use the reptilian parts of our brain. Only when we feel safe and under control of ourselves we get the full ability of our cortical brainpower. And then we can reach the room which the English psychoanalyst D. W. Winnicot described as the intermediate room where fantasy, love and fairy tales meet.

So why not try to use more of Expressing Arts in today's psychiatry. It will certainly help our patients and perhaps you will find your own work more rewarding as well. ■

Text, photos and drawings by Svante Bäck
(if not other mentioned in the text.)

Psychopathology and the Cinema

Pia Glyngdal

Movies stimulate more than just our visual acuity. Movies are able to produce thoughts, feelings and different states of mind in the viewer, guided by the director. To watch a movie is to be manipulated and seduced. When we allow ourselves to surrender to the cinematographic screen, it is possible to have experiences that might be similar to those of our patients, thereby achieving a supplementary psychopathological understanding.

Pia Glyngdal
MD Psychiatrist with private clinic.
Pia Glyngdal is a Danish psychiatrist trained in general psychiatry in Copenhagen, where she has worked for most of her career. Her main psychiatric interest has been in dynamic (partly Jungian) psychotherapy.

Since the creation of motion picture – some 120 years ago – psychiatry has been used repeatedly as an element or the main theme in movies. Psychiatric themes are exquisite tools to tell a story: Psychiatric illness displays the individual's estrangement from the surroundings. Changes in a psychiatric illness provide a storyline. Madness may be used in crime and horror movies to portray the dangerous and unexpected. Psychiatrists (or psychiatric nurses), who are supposed to be caretakers, have often been portrayed as evil authority figures. This dichotomy is much more threatening than a mean and aggressive crook.

Movies are intended to tell a story – not to tell the truth or expand the general knowledge of psychiatry. Therefore, the psychiatric reality, as we know it, is often bent and difficult to find. According to the cinematographic truth almost all psychiatric sufferings are caused by childhood-trauma. The cure is either love or the cathartic recovery of repressed memory, and until the end of the last century psychiatric medication is described as making you heavily sedated.

Nevertheless, movies may render information about psychiatric topics, which are otherwise difficult to understand. From the movies psychiatrists can get new and expanded understanding of their patients sufferings, and concepts may be taught more easily to trainees.

In 1919 Karl Jaspers wrote: "… the entire field of psychopathology concerns itself with actual experiences …". Films are particularly well suited to depict different states of mind. When the viewer surrenders himself to the screen, the director takes over - constructing the reality of the movie and for a while that of the viewer. Using not only the talents of the actor, but also the setting of light, the colors, the angles and distance of the camera, the music and the pace in the cutting, the director can make us perceive, think and feel, what he wants. What emotes from the screen makes us believe, that we are actually experiencing, what is happening up there. The viewer enters a trance, a state of absorption and attention with thoughts and feelings like those, which occur in the stream of consciousness. The emotions of the characters are not told to us, we experience them, and we begin to feel like the protagonist. Seeing a movie could make us experience the same as our patients.

Most of the symptoms in affective disorders are easily recognized, since they are extremes of normality, whereas schizophrenic symptoms are harder to comprehend, because they are anomalous experiences. In several of the films directed by David Cronenberg the emergence of the unreal, the supernatural and the hallucinations are depicted in such a sensual and material way, that it makes us feel, how disgusting and intruding a psychosis might be. When we see *The Truman Show* (Peter Weier) for the first time, we experience derealisation along with the main character.

The film media is exquisite in showing the change from normality to manifest psychosis with maybe an apocalyptic Weltuntergang-erlebnis. In movies like *The Tenant* (Roman Polansky), *A Beautiful Mind* (Ron Howard) and *Black Swan* (Darren Aronofsky) we follow the progression of the illness from the protagonist´s view, and we experience how the reality-testing weakens. By watching these movies, it is easier to understand the gradual development from sanity to psychosis, and why our psychotic patients have such a poor insight.

In artistic movies the pace is slower, there is less action and maybe more speech. This is done deliberately to allow the viewer the time and space to reflect. The spectator's involvement becomes less emotional and more intellectual, which may permit another enlightening. Finally, two contemporary Nordic films, where aspects of depression are in focus, may exemplify this. In *Melancholia* (Lars von Trier) a huge planet is going to destroy the earth. Depression is portrayed as a devastating power, that controls the person who has no future. In *Oslo, 31. August* (Joachim Trier) a young suicidal Norwegian is walking around the tortuous streets of Oslo. Depression is shown as causing an isolation, that keeps the protagonist separated from the rest of the society. The circular narrative structure highlights depression as an inner subjective prison. ■

Futher reading:

Richard Allen, Projecting Illusion, Film, spectatorship and the Impression of Reality, 1997, Cambridge University Press.

Davide Caputo, Polanski and Perception: The Psychology of Seeing and the Cinema of Roman Polanski, 2013, University of Chicago Press

Glen O. Gabbard et al, Psychiatry and the Cinema, 1999, American Psychiatric Press

Jeppe Mørch Jensen, Depression, Isolation og circularitet, skildringen af melankolisk depression i samtidige skandinaviske kunstfilm. Kandidatspeciale, University of Copenhagen 2017. Abstract in English

David J. Robinson, Reel Psychiatry: Movie Portrayals of Psychiatric Conditions, 2003, Rapid Psychler Press

Danny Wedding et al, Movies & Mental Illness, using films to understand psychopathology, 2014, Hogrefe Publishing

Two motion pictures and psychiatry

Óttar Gudmundsson

Óttar Gudmundsson, MD
Psychiatrist. Landspitalinn, University Hospital, Reykjavik Iceland

Hospitals and medicine have for a long time been highly popular topics among filmmakers. Illness, suffering and death are always dramatic events and are likely to attract attention. The science of psychiatry is no different in this respect than other disciplines.

The film, *One Flew Over the Cuckoo's Nest* by Milos Forman greatly affected people's opinions about psychiatry. The film is about an outcast, Randle McMurphy, who fakes it in order to get admitted to a psychiatric institution as a way to get out of prison. He gets to know the situation at the institution, an inhumane environment and abuse of power. Randle tries to organize the patients in order to defy the powerholders, the medical doctors and nurses. The film ends with Randle's total defeat. He is made to undergo lobotomy and the last scenes show the audience an individual who is totally without any will and personality. However, his friend, the big Indian, managed to escape from the institution.

This film was a box-office sellout in Iceland as well as in other parts of the world. Everyone seemed to have seen it and it affected people's opinions about psychiatric institutions. The film was released in 1975 when efforts were being made to make the environment at the psychiatric institutions more humane. The film illustrates a psychiatric ward of the past in most Western countries. People believed that the film gave a realistic image and that lobotomy was being used to silence and control unruly patients. However, the film also confirmed all the prejudice people had about psychiatric institutions.

Another motion picture giving a grim image of psychiatrists is about a psychiatrist, Hannibal Lechter and his treatment of patients. Anthony Hopkins created an unforgettable character in the film. He was conveyed as a highly intelligent and super charming person, yet a person using questionable means to say the least. Lechter turns out to be a mass murderer who literally eats his patients, cooked and prepared in a gourmet fashion. No one recognized his/her psychiatrist in this character of the film. Lechter was particularly captivating and skilled.

The film, *One Flew Over the Cuckoo's Nest,* was even more influential. These were years of much discussion about anti-psychiatry under the initiatives of Ronald Laing, Thomas Szasz, and David Cooper. The works of these authors drew a black image of the activities power abuse at psychiatric institutions.

The discipline of psychiatry and its servants are defined as the tools of the powerholders to oppress others. The film caused incredible damage to the development of psychiatry. These are classroom examples of how people's opinions can be molded by fueling their prejudice. ■

Cinema and Psychiatry

An interview of philosopher Nerijus Milerius by psychiatrist prof. Arūnas Germanavičius

Translated by Ramunė Mazaliauskienė

Introduction by Ramunė Mazaliauskienė
Cinema and psychiatry are a never-ending love story. Both has influence on each other. Both causes a lot of discussions, controversies, etc. Below you can read a talk of two professionals – psychiatrist and philosopher. They discuss the role of cinema in general, they review some aspects of cinema in Nordic and Baltic states. Enjoy!

A.G. I will start with a historical question, chronologically psychiatry and cinema appeared at the same time, in the middle of XIX century, both of these areas are interested in human being; when talking to a human being, revealing personal stories, analysing the language, imagination, dreams, and images. According to Federico Fellini, both cinema and language are made of images, like a dream: "Talking about dreams is like talking about movies, since the cinema uses the language of dreams; years can pass in a second and you can hop from one place to another. It's a language made of image. And in the real cinema, every object and every light mean something, as in a dream" (Levine 2020). https://walkerart.org/magazine/dreams-cinema-history-matt-levine?fbclid=IwAR0Hck7LvgsgEjqPfWYDac5bgVWa1HR-h7cLbavT-0pvQXZMtICNsMzXAPE While investigating the history of ideas, can we see what is the influence of psychiatry and psychoanalysis on the development of cinema?

N.M. It is quite natural that for cinema – which is a very ambitious art – only the simple "external" event representation was never enough; it started portraying events as externalization and projection of inner mental world. Therefore, it is not surprising that by interconnecting visuals with a usually invisible to the human eye mental content, cinema has turned to a field which has succeeded much more in the investigations of the psyche. Undoubtedly, an additional impulse was given by the structural similarity that cinema makers and interpreters considered to exist among

Nerijus Milerius
was born in Vilnius in 1971. He is Associate Professor of Philosophy at Vilnius University, Lithuania. He is teaching film philosophy, religious cinema, cultural studies and aesthetics. He is the editor and one of the authors of the monograph "Film and Philosophy" (2013), the author of the monographs "Apocalypse in Cinema: The Philosophical Presuppositions" (2013) and "Viewing the Viewer: Cinema and Violence" (2018). Milerius is co-director of the documentary film "Exemplary Behaviour" (with Audrius Mickevicius, released in 2019) and co-author of the script of "Isaac" (director Jurgis Matulevicius, released in 2019).

Arūnas Germanavičius,
MD, PhD 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 is editorial board member of several journals, including Nordic Journal of Psychiatry.

cinema and dreams. Watching this specific sequence, which is quite common for movie shots (pictures), and evaluating the difference that exists between movie shots and the real sequence of events, it seems that the "logic" of dreams is quite good for the associative defining of the movie shot connection "logic".

It is a widely acknowledged fact that cinema – especially commercial – has always been more interested not in the norm, but rather in anomaly, therefore, it is not surprising that cinema has acquired knowledge, stories and images from the performed investigations in psychopathology. On the other hand, it would be a mistake to think that cinema unconditionally adopted the experience of psychiatry. cinema did not only enthusiastically show the various forms of psychopathology but also attempted to create disclosing stories about the normalising functions of the psychiatry itself. Now it is evident that cinema not only used the experience of psychiatry by creating stories of its own, but it also criticized psychiatry by more or less stereotyping it. Influence can be experienced not only by receiving knowledge, but by criticizing as well, such form of influence is quite common in science where the desire to clarify or to deny the position of the authority is the engine for the development of the scientific investigations.

A.G. In the XX and at the beginning of XXI century cinema has survived the competitional fight with television and was an important media in which the plot of the movies becomes a part of our imagination. But when do the images, hallucinations, or delusions of patients treated by psychiatrists become interesting to filmmakers?

N.M. Mental disorders, hallucinations and delusions were interesting to the filmmakers since the beginning of cinema. Such an interest can be explained by many reasons, but let's mention at least two of them – one more general, another more interconnected with specifics of the cinema itself. First, as Anthony Giddens has stressed, in modern society excesses – like criminality, sexuality, madness, death, etc. – are sequestrated, separated from the daily rhythm of the routine. But what modernity separates from daily routine rhythm, media returns in shape of stories, news and images. Looking from such aspect, we must make a conclusion – cinema's interest in madness (as well as in criminality, sexuality, death) is predicted by the specifics of modernity itself. Secondly, mental pathology being unusual was a perfect material for cinema longing for exceptional stories and unexpected turns. Long ago Aristoteles described peripeteia - an abrupt and unexpected turn of the story action – as one of the essential elements of poetics. Mental pathologies can look like Klondike of such peripeties able to change the story radically. Such peripeties are not necessary to create, they are a part of mental pathologies. We can remember the famous R. Wiene's The Cabinet of Dr. Caligari (1920) turn of the plot when during the whole movie there is a story told about macabre doctor Caligari, but at the end it is evident that the story teller is a patient of the mental hospital, and doctor Caligari is a director of this hospital. Though there are ambiguous evaluations of this movie and its ending, but for a spectator it offered an incredible thing – to look at the world with the eyes of a mentally ill person.

A.G. How does the cinema influence psychiatry?

N.M. Cinema – as a mass form of art – makes public of things that without cinema would stay only between one professional group – psychiatrists. So, cinema in a bigger dimension acts as a moderator between psychiatry and society. We have to accept, of course, that sometimes by simplifying the figures of both, the psychiatrist and the patient, cinema moderates not in a way that would be expected by the community of the psychiatrists. However, there are many examples of movies that are being used for both, educating future specialists and self-improvement. Even more, in certain cases, like, e.g., movie "Gaslight" (1944, directed by G. Cukor) cinema acts as magnifying glass – it visualises a certain mental phenomenon which becomes more interesting for psychiatry as well.

A.G. There is another side of the cinema – in it certain pathologies of reality, abuse is shown in a condensed way. What is the importance of cinema in the understanding of abuse, its origins, ways of dealing with it? Can you give examples?

N.M. Having in mind the fact that cinema tends to visualise everything that is sequestrated by the modernity, showing madness through the lens of criminality – criminalisation of mental disorders and pathologies- would not surprise us. But there exists cinema that doesn't make up to dominating tendencies but prompts to understand it and criticizes it. In this aspect filmmaker Michael Haneke is especially important. In his short programming text "Violence and the Media" Haneke formulates his position, where the most important thing is not to advocate violence or to forbid it, but rather to create conditions which could allow spectator to raise questions about his own attitudes to the visible violence. Notable that creating such conditions for the reflection of violence Haneke created few movies that are known for ultra-violence. Such a position of Haneke to criticize violence using maximal violence was called "A performative self-contradiction" by cinema theoretic Thomas Elsaesser. It is evident that criticizing violence using pictures of violence is a contradictory and risky position, on the other hand, only by attempting to take the risk and not ordinary solutions have the biggest potential to knock the spectator out from a comfortable position of a violence user or superficial moralizer.

A.G. We know a lot about the fact that images can have a destructive effect on a person, provoke violence, impulsive actions or an imitation of violence acts. Could the imaging of violence in movies be useful? What are some of the important conditions to understand the images of violence in the movies as meaningful, having therapeutic value?

N.M. This question could be understood as prolongation of your previous question, and for that reason it is comfortable to answer it using an example of Haneke. His movies are not only brave and risky, but – at least for me – irritating and uncomfortable. It was noticed that in commercial cinema a certain contract is made between filmmakers and viewers – the viewer agrees to accept the most violent images of the cinema, but at the same time perfectly knows that as a reward he will receive esthetical satisfaction or, what I like to emphasize, an institutionalized catharsis. Such aesthetisation of violence is a big problem, cutting off the possibility to understand the specifics of visual violence. For that reason, even if it sounds paradoxically, most valuable violence criticizing movies radically breaks aesthetical contract, they refuse to guarantee aesthetical satisfaction, and are programmed as anti-cathartic. Paradoxically, this way they can perform the awakening of the reflection or a therapeutic role.

A.G. Cinema can unfold personal pathologies. But can we see that in one of the most influential visual arts – cinema – there is a curing element? What cures in cinema according to you?

N.M. As many things related to psychiatry or psychology, therapeutic effect of cinema is covered with many stereotypes. It is admitted that when presenting cases of mental disorders, cinema exploits the idea of "miracle recovery" after one remembers some traumatizing event and brings it into the daylight. But after stating that the power of cinema stories, and the cinema in general, is over-estimated, we must not under-estimate it. Talented cinema creations can be as effective supporters in inner inquiry as other forms of self-reflection.

A.G. Cinema as a form of art is a reflection of the relationship between psychiatry and society. We know a lot of examples in cinema when psychiatric practices or institutionalized violence in psychiatry are shown in a negative way (e.g. Miloš Forman "One Flew Over the Cuckoo's Nest", Stanley Kubrick "A Clockwork Orange", etc.). What examples from cinema had a positive impact on society in decreasing the stigmatization of psychiatry and psychiatrists?

N.M. If to look at psychiatry through the lens of the attitudes of M. Foucault, as to an institution of control, disciplining, and categorization of what is "norm", and what is anomaly, then the critical image of psychiatry in cinema is inevitable. The movies you have mentioned I consider to be brilliant creations which, even after exploiting certain clichés and stereotypes about psychiatry, are still attentive to the basis of criticism itself. "One Flew Over the Cuckoo's Nest" criticizes not only psychiatry, but the whole mechanism of the disciplinary system where an individual is required to be a useful individual, performing a strict social role and the role that is attributed to him; for that reason in a mental hospital you have to be "a patient", and not somebody else. "A Clockwork Orange" has bigger aspirations, and its target is the wish of a totalitarian state to control everything, including one's mind. Unfortunately, how the totalitarian state uses psychiatry we know not only from the movies or other art pieces, but also from history, and that the totalitarian state medicalizes opposing political elements is a well-known fact.

But we must agree that in cinema there are many more examples that are considered untalented and rudely stigmatizing psychiatry. I believe that the more important movies are not the ones that exploit an exclusively positive image of a psychiatrist – there are many stereotypes constructing one – but rather those that address the subtilities of psychiatry, not stereotypes and stigmas. I would consider Ingmar Bergman's "Face to Face" (1976) to be one of the best examples of it. Yes, here we have a psychiatrist who suffers from mental illness herself. But the way Bergman goes deep into the specificity of mental phenomena makes this movie one of the best examples of this kind.

A.G. How has the portraying of abuse in psychiatry changed in modern cinema and TV series?

N.M. As K. Gabbard and G.O. Gabbard have described, almost the whole time, except for the "golden age" of psychiatry depiction in the fifties and sixties, the cinematographic image of psychiatry has been rather negative than positive. Even brilliant movies, such as "One Flew Over the Cuckoo's Nest", did not avoid stereotyping, e.g. the portrayal of electroconvulsive therapy as an instrument of repressive abuse. Though there is a clear tendency in today's cinema to emphasize negative characteristics of psychiatry, the cinematographic examples of depicting psychiatry are much more complex and revealing the complexity of the relationship between psychiatry and society.

A. G. I have a specific question about the trends of national cinema in the Nordic countries (Scandinavia and the Baltic states). How much was it influenced by psychiatry and psychoanalysis?

N.M. Though sometimes the movies of the Swedish film director I. Bergman and the Danish film director L. van Trier have been said to be controversial, the creation of these movies is enough to state that the theme of psychiatry and psychiatric pathology has left a mark in Scandinavian cinema. It is not just once that I. Bergman has turned to the figure of a psychiatrist and psychoanalyst, and von Trier constantly returns – usually in a controversial and scandalous manner – to various forms of psychopathology. It should not be surprising that there is a lack of attention for psychiatry in the Baltic countries, especially because of the institutionalization of psychiatry during the Soviet times. Even the independent Baltic cinema still has to find the means of how to make psychiatry and psychotherapy a part of cinema. For example, the only brighter example of Lithuanian cinema, where the relationship between a patient and a psychotherapist could be seen, was "Whisper of Sin" by A. Puipa; the movie is about a psychotherapist who took over the patient's obsessions and committed a suicide at the end.

A.G. Finally, I would like to ask for your opinion about the attempt that the Lithuanian movie "Summer Survivors" made by showing the experiences of a person treated in psychiatry and the tendencies of the modern Lithuanian cinema, its attempts to talk louder about psychiatry and the problems related to it?

N.M. This question could be viewed from a more general perspective; what do we expect from cinema, factual precision or a creative reconstruction of the reality? I don't think that a precise factual precision is even possible in cinema. For me, the intention of how the creative reconstruction of the reality is being implemented is much more important. For that reason, I consider "Summer Survivors" as a positive try which avoided stigmatizing psychiatrists, refused demonizing patient's mental disorder, and delved deeply into the existential world of those who suffer from mental disorders. ■

Using Movies in Psychiatric Education

Oddur Bjarnason

Movies are an effective artistic medium. A good movie can affect us profoundly, and we may perceive the experience as if we are participants. We are drawn into the story and the experiences and emotions of the characters and can relate to them emotionally and intellectually.

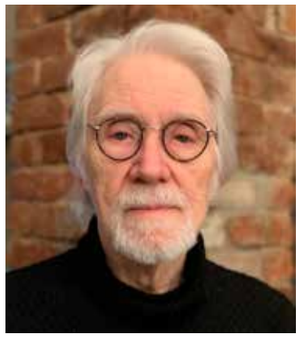
There exist a large number of movies with main characters with severe mental disorders. They can effectively be used in teaching psychiatry to medical students and medical residents and are used in some medical schools and psychiatric departments. I did that when teaching in the psychiatric hospitals of the University of Iceland and University of Bergen, and found that the students showed great interest in the movies and in discussing them. The author is convinced that the courses increased the students' knowledge and understanding of psychiatric patients and their disorders.

Courses can be arranged presenting movies with characters that have severe mental problems or mental disorders. They should have relevance to teaching about these disorders and should have high artistic value. The following link gives access to a network database with information about such movies, their characters, and their mental disorders:

https://embed.kumu.io/db7d43b7252ecbdcdecfb03dac6af083#psychiatry-and-the-arts/movies-and-psychiatry

Movie Information

A movie course allows learning to make a diagnosis/differential diagnosis and to discuss a mental problem/disorder within the disease-psychodynamic-cognitive/behavioral-social frame of reference and which aspect of that model is most relevant to the mental problem/disorder exemplified by a character in a movie. In this context, the author should like to direct the reader's attention to the excellent book "Models for Mental Disorders" by Peter Tyrer. Mental disorders may also be discussed relative to other theoretical frames of reference. In this regard, it would be advantageous to invite other professional groups, e.g. psychologists, social workers, to course sessions.



Oddur Bjarnason
Psychiatrist

I shall use Medea by Evripides and Lars von Trier as examples of using plays and movies in teaching psychiatry.

The Myth of Medea

A Guide to Euripides' Medea

Medea before Corinth

Medea helped Jason, leader of the Argonauts, to obtain the Golden Fleece from her father, King Aeëtes of Colchis. She married Jason and fled with him pursued by Aeëtes. Jason, in conspiracy with Medea, cut her brother Apsyrtus to pieces and threw him into the sea to delay the pursuit.

They then went to Jason's hereditary kingdom of Iolcus, where his uncle Pelias had usurped the throne. To get rid of him, Medea convinced his daughters that to restore his youth, he would have to be killed, cut to pieces, then put together and restored to youth by Medea's magic, which she, however, withheld. After this, Jason and Medea, together with their two children, were forced into exile and fled to Corinth.

Medea in Corinth

King Creon of Corinth wants to secure his throne. To do this, he wants to marry the victorious warrior Jason to his daughter Glauce. Jason accepts although he is already married to Medea. Creon decides to banish Medea and her two boys from the city. She entreats him to let her stay, but he gives her only one day to secure the needs of the two boys.

Medea agrees with Aegeus, the king of Athens, that she can come to live in Athens under his protection. She then murders both Glauce and Creon and her children to punish Jason for his betrayal.

Medea after Corinth

Medea became the wife of Aegeus, who later drove her away after her unsuccessful attempt to poison his son Theseus.

The following are some of the questions that course participants might ask and discuss:

1. Is the play/movie of high artistic quality?
2. Do the symptoms portrayed by the main character correspond realistically to symptoms of a mental disorder?
3. How would a performance/showing of Medea by Evripides or Lars von Trier be experienced and understood by:
    a. an ancient Greek
    b. a contemporary person without a mental health education
    c. a contemporary mental health professional, psychiatrist, Freudian or Jungian analyst, a cognitive or behavioral psychologist, a social worker, a psychiatric nurse?
4. What is the significance of the social, cultural and historical context in shaping representations of mental illness

The application of DSM5 to the symptoms Medea demonstrated by her words and deeds during her sojourn in Corinth shows that she fulfills all the criteria for General Personality Disorder and at least five of nine criteria for Borderline Personality Disorder. She does not fulfill the criteria for any other personality disorder. According to ICD-11, she has a Personality disorder, Severe, Borderline pattern.

Some people have argued that her actions can be understood as a normal reaction to Jasons' betrayal. However, when we take Medea's actions throughout her life into account, there is not a shadow of a doubt that she has a Borderline personality disorder and at least traits from other personality disorders. She exhibits symptoms long before Jason betrays her.

Other important questions that we might discuss during a course section are for example:

1. Does the application of psychiatric diagnostic criteria and the assignment of a diagnosis enhance the experience and understanding of Medea derived from attending a performance/showing of Medea?
2. What is the primary purpose of applying psychiatric diagnostic criteria to Medea and other characters, as well as psychiatric patients?

Conclusion

Because of the intense emotional and intellectual effect of movies of high artistic quality, they may be used for teaching psychiatry to medical students and medical residents. They can increase their knowledge and understanding of psychiatric patients and their disorders. ■

Ambassador for the Gospel of Death?

Interview with musician and author Sami Lopakka

Hanna Tytärniemi

"I'll drink the booze to depress myself
then I take the rope and express myself
I'll leave this world without shedding a tear
without hope, without fear

Yeah, I think I'll put my head
into the Noose and let it all go...and so I will
Oh yeah, I will"

(Citation from "Noose", song by Sentenced, lyrics by Sami Lopakka)

Official music video: https://www.youtube.com/watch?v=UzWhK9aBSbE

Sami Lopakka, musician and author. Project manager in an employment project for academics. Guitarist and main composer in Finnish metal band KYPCK (2007-). Guitarist and main lyricist in Finnish metal band Sentenced (1989-2005). Lopakka has written two novels (in Finnish): "Marras" (2014) introduces a fictional disastrous and delirious venture of a Finnish heavy metal band touring around Europe. "Loka" (2019) describes the lives of three suicidal men struggling between depression, substance abuse and suicide. Photo: Vesa Ranta

Sami Lopakka is a Finnish musician and author. He was the guitarist and main lyricist of the former heavy metal band Sentenced. Sentenced reached worldwide success and toured repeatedly around Europe and overseas. Death, suicide, anxiety and depression were the common topics in their production. Lopakka currently plays guitar in a Finnish Doomsday metal band called KYPCK. The group perform their music in Russian language and tour mainly in Russia and Eastern Europe. Lopakka has written two novels in Finnish, both introducing several suicidal or otherwise severely anxious characters.

Q: You were only 14 years old when you started writing lyrics for Sentenced. Death has been one of your main topics throughout the years. Where is it coming from?

Sami: Ever since I was a child I have been attracted to darker topics and I have been prone to anxiety all my life. At times anxiety or depressive periods have been stronger and at times weaker but anxiety has always been somehow present. It's an awful feeling but offers an endless source for artistic processing! It was like an awakening when I first became aware that at some point life will end for each one of us.

I'm happy that my artistic style has grown since the first teenage years of mimicking others. Nowadays I can use my favorite topics more diversely in my artistic expression.

Q: For an outsider heavy metal or gothic death metal may contain shocking and prominent content. Some of your lyrics and the stories in your novels are actually quite shocking or even disturbing. Are you intentionally seeking shocking effect?

Sami: I am trying to give death the natural attention it deserves. Surely there are some categories in metal music that use satanism or other deliberately shocking elements. Minor key music would also sound terrible with cheerful lyrics. I'm interested at writing about issues that are really true and really happening in our world although not often discussed openly. For instance, there are huge cultural differences in approaching death as a topic. In Western and Nordic cultures death is a taboo of some kind although none of us can escape it. Whereas in Mexico they actually have a great celebration around death on the Day of the Dead. I want to write about these forbidden topics or heavy issues. It could actually give possibility for others to seek help or talk about them too.

Q: It seems that you don't take death too seriously? You have even adopted an artistic nickname "The Serial Self-Killer" in some of your lyrics and similar

"- I'll kill myself:
I'll blow my brains onto the wall!
- See you in Hell
I will not take this anymore!
Now, this is where it ends
This is where I will draw the line
So, excuse me while I end my life"

(Citation from "Excuse Me While I Kill Myself",
song by Sentenced, lyrics by Sami Lopakka)
Film clip from a gig in Finland:
https://www.youtube.com/watch?v=KRLrkMyediw

black humor is present in your texts. Your novel characters end up in craziest circumstances that make the reader sometimes even laugh out loud although the situation could be closely associated with suicide or most humiliating or painful settings. On the other hand, there are several occasions that bring out a shared sense of shame in the reader. You like to cross borders in your art, don't you?

Sami: Death is a natural phenomenon. I try to find humor even in situations where it is not thought to exist. I think art offers the possibility, or even obligates us, to go far beyond any limits. But there are some moral limits that I want to respect. For instance, one of my novel characters is a doctor who feels suicidal himself. Is it okay for him to share his thoughts with a patient who has tried to kill himself? It would be criminal not to discuss the unsuccessful suicide but how far can a doctor go in these discussions?

Q: Heavy indeed! Some of your novel characters seem pretty severely depressed. Their suicidality is deep, prolonged and well-considered. They have zero percentage of seeking attention while attempting suicide or thinking about it. Instead they seem to yearn to die. Do you find some kind of glorification in the idea of death or suicide?

Sami: My characters often carry heavy anxiety. It may spring from shame, alcohol problems, historical family related issues or difficulty of being yourself etc. Death or suicide may be seen as an end point to the agony of anxiety or depression. I have never been religious, and I don't see a chance for some kind of afterlife. There is one end for each of us and we should use this one life the best way we can. For some and at times, death may represent a gateway out of misery, and I respect that possibility. In fact, over the years Sentenced received countless number of feedback and letters from our listeners worldwide, stating how our music had helped them survive difficult phases of life. Many get comfort and support from this heavy but upfront content.

Q: Is it therapeutic for you to write about agony, death and pain?

Sami: It has a cathartic and invigorating effect. I need some kind of drain where to pour the buckets of negative thoughts one by one. On the other hand, writing about death can become too heavy if overdosed. Years ago, when I was preparing my master's thesis, I came across this feeling. My work involved studying the metaphors of death in the obituaries. I spent my days sitting in a small room, having walls covered by hundreds of obituaries. In the evenings I continued writing song lyrics from the same themes. After a year or so, I felt my head would soon burst! Nowadays I'm happy to combine a typical day job and family life to balance the artistic areas of life. KYPCK is planning next studio recordings in the autumn. ■

Suicide in opera

Hans-Peter Mofors

“The opera ain’t over till the fat lady sings” or in some cases dies. While most operas end in a dramatic aria, it is also true that many operas end tragically with death. Suicide is not uncommon in opera and has been portrayed as both impulsive and contemplated. Suicide is the most extreme consequence of psychiatric illness - the culmination, when the person feels that there is no other way out.

Significantly more women than men pass away in operas, both due to natural causes and due to suicide. Among the men, especially tenors, a hero’s death is often the case. Among the bases and baritones, death is very scarce. This is probably because the stoic roles are reserved for these voice types.

As the audience, we suffer and grieve with the characters, but paradoxically at the same time, delight in the sensory pleasure of the beautiful music. It can be a cathartic experience, evidenced by the often boisterous and enthusiastic cheering from the audience after the curtain fall. To the uninitiated such a response may seem a bit strange.

In this article, I will present and describe some of opera’s most well-known suicides, and try to analyze them from a musical and psychiatric point of view. Follow the links in the article to experience the scenes yourself!

Few operatic suicides are as famous as the one of Madame Butterfly. Her husband Pinkerton comes back to Japan, and has now married "for real" in America. He is now in Japan again to bring his and Butterfly’s son to America. The shame is complete and Butterfly’s honor destroyed. Hara-kiri remains the only recourse. In the final Pinkerton rushes into the house, calling her name. Has he repented? Now it is too late. Butterfly stabs herself with a knife in the abdomen in front of his eyes. In a rousing Japanese influenced musical finale, the curtain falls. https://www.youtube.com/watch?v=9FfhWTMjKQk (Watch from 2,16,00)

Butterfly's suicide is crisis-related and of an impulsive character. An assumed future social exclusion and immeasurable grief means that she sees no way out. Butterfly's suicide would probably have been prevented

Madame Butterfly
Photo: Kungliga Operan, Stockholm

with better support from family, society or friends and with a more empathetic approach from the callous Pinkerton. Many real-life parallels can be drawn. We are seeing more and more suicides among young people, related to feelings of shame and guilt associated with different life challenges. In Asian countries for example, failure to live up to parents' demands and academic failures is a significant cause for suicides among youngsters.

In the operatic masterpiece" Tosca", the leading lady commits an even more impulsive suicide. Her beloved, who would have been executed, now lies dead in front of her feet. The disaster is real and she currently sees no alternative but to throw herself off the edge at Rome's Castel Sant'Angelo. Again, Puccini the composer, chooses the most dramatic musical expression imaginable. And the audience cheers. It's understandable, but at the same time also bizarre.
https://www.youtube.com/watch?v=n6kTmWYIAcw (Watch from 0,30).

However, Tosca's type of impulsive suicide is not so common. Most people would not choose to end their lives abruptly after a severe life crisis. In the context of impulsive suicide, any form of prevention measures would be almost completely impossible.

Tosca. Photo: Kungliga Operan, Stockholm

As a reaction to loss, reuniting with the dead one is a common theme found in opera. Isolde's "Liebestod" or love death is one of the most beautiful pieces of music ever composed. After Tristan's death, Isolde slowly disappears into the realm of death to the magical tones of the Liebestod - to reunite with her beloved. https://www.youtube.com/watch?v=gbbEBt5mP6w

. Another story of the idea of reunification through death can be found in the opera "Suor Angelica". After being informed that her son had died of an infection, Angelica begins showing clearer signs of mental illness. She hallucinates that he calls out to her, to meet in paradise, and chooses to poison herself. Before the impending hour of death, she however repents. Suicide is a mortal sin in Catholicism and she has condemned herself to eternal damnation but alas it is too late! Watch and listen here. Can you keep you from crying? https://www.youtube.com/watch?v=mAUH-UpCe8cs (Watch from 1,30)

Birgit Nilsson as Isolde.
Photo: Kungliga Operan, Stockholm

Twilight of the Gods.
Photo: Kungliga Operan, Stockholm

The last two suicides are interesting from a psychiatric point of view. Fantastical ideas and conceptions of death in various forms often occur among people who have suicidal thoughts. In our work as psychiatrists, it is profoundly important to talk through these ideas with the patient and to achieve some sort of reality check. For the purposes of suicide prevention, it is important to identify which factors have made the patient want to live so far and instead try to strengthen these thoughts.

A common belief is that suicide is contagious. In Massenet's opera "Werther" based on Goethe's novel "The sorrows of young Werther" the young protagonist suffers from the unhappy torment of love. He is constantly depressed and communicates suicidal thoughts several times. In the final scene, he shoots himself. https://www.youtube.com/watch?v=rBV3NW550zw . It was however the book that led to the first described cases and wave of "copycat suicides", the so-called "Werther effect", where young men tried to emulate Werther.

Werther's suicide would probably have been avoided today. He suffered from maladaptive stress, poor coping strategies and even of depressive symptoms. In any case, a fairly uncomplicated psychiatric intervention could have prolonged his life, returned him to normal functioning and possibly prevented his death.

It can be debated whether suicide is contagious or not. The "Werther effect" is real but is possibly more the result of the type of media reporting of a suicide and the details of how the suicide was committed. By avoiding these details in the reporting by the media and focusing more on the tragedy (both for the deceased and the ones left behind), the incidence of copycat suicides will be reduced.

A less interesting suicide, at least from a psychiatric point of view, is Brünnhilde's heroic suicide. After she has set fire to the dwelling of the gods, she chooses to ride into the flames, even here with the intention of being united with her beloved. After eighteen hours of glorious musical excess the world finally burns up, followed by the drowning waves of the flood. We have reached catharsis and a new era can begin. https://www.youtube.com/watch?v=2Jg-Mt8GWdyU (Watch from 15,00)

The world of opera is a fascinating treasure trove. I hope that I have piqued your interest in this art form, not only for its obvious musical offerings, but also its' intriguing portrayals of the human psyche. ■

What happened to music therapy?

Interview with Brynjulf Stige

Ola Marstein

Brynjulf Stige
PhD, Professor in Music Therapy, University of Bergen; Head of POLYFON Knowledge Cluster for Music Therapy; Co-editor of Voices: A World Forum for Music Therapy. Main interests of research include mental health, older adult health, community music therapy, and music therapy theory and philosophy

Back in the 1980's, a new profession entered psychiatric wards – the music therapist. Together with other arts therapists, they supplemented the doctors and nurses in the staff. But they were newcomers, and never really managed to establish themselves as natural team members. Then in the Norwegian national guidelines for treatment of psychotic disorders (2013), music therapy entered center stage, with an A in evidence base for efficacy. What had happened?
Professor Brynjulf Stige at the Grieg Academy, Department of Music at the University of Bergen is a key figure in European research in music therapy.

What can music therapy bring to psychiatric patients?

We can examine music therapy's contribution to mental health along three dimensions; complementarity, acceptability, and sustainability. Treatment of persons with psychotic disorders illuminates the complementarity dimension; the effects of music therapy on negative symptoms are well documented compared to standard treatment, including medication and verbal psychotherapy. We also have studies that demonstrate music therapy's acceptability among patients with little motivation for more conventional therapies. And, we see that many patients start using music activities in their everyday life, after having had music therapy in the clinic. Musical participation has great potential as a sustainable resource for mental health in the community.

How has the development of music therapy proceeded in the academic world?

If we want to understand what happened to music therapy after the pioneering practices in the 1980s, this question is central. In a way, those early practices were "feasibility studies." They demonstrated music therapy's relevance within mental health services, but there was no foundation back then for scaling this up to systematic implementation nationally. There were no national recommendations of music therapy, and we did not have the capacity for training and research that would warrant this. To build these capacities has been a priority the last four decades. Today there are two education programs at the university level in Norway, one in Oslo and one in Bergen, both with internationally oriented research centers. The Research Council of Norway has evaluated Norwegian music therapy research twice, and has found it to be in the international frontline, so the efforts have started to pay off.

Which patient groups are benefiting the most?

Because music therapy is still a young research discipline, we have to distinguish between what the Cochrane reviews tell us and what other sources of knowledge indicate. When it comes to Cochrane reviews, the evidence is strongest in the treatment of patients with depression and patients with psychotic disorders. Clinical experience and a range of research studies indicate that several other groups benefit as well, such as patients with neuro-degenerative diseases, substance use problems, or trauma-related problems. As I mentioned initially, there is also evidence demonstrating that music therapy can be motivating and helpful for patients with low therapy motivation, across diagnoses.

How is music therapy performed?

Music therapy is relational practice, tailored to each patient's problems and resources. A range of musical activities might be involved, such as listening, playing, singing, composing, improvising, or dancing. User-involvement and empowerment is central, while the role of verbal reflection varies, depending on the needs of the patient. For some patients, one of the major advantages of music therapy is that it allows for communication and relationship building beyond words.

Is this applicable only to patients who are familiar with an instrument or are active singers?

Absolutely not! Music therapists work with patients with very little musical experience as well as patients who are amateur musicians, or even professional musicians. To be able to work flexibly with whatever musical resources and interests the patient presents is one of the key competencies of the music therapist. The reason why it is possible and relevant to work with persons with minimal musical experience is that we all share a biologically evolved human 'protomusicality,' by some researchers labelled 'communicative musicality'. Even newborn babies are motivated for and able to engage in interaction through sounds and rhythms.

Can music therapy give us as physicians new knowledge about the brain and its functioning?

There has been an explosion in our knowledge about music and the brain the last 20 years. Neuroplasticity and the neural encoding of emotion are two of the areas of study. Clinically, this is very

promising, and last year NIH awarded $20 million over five years to bring neuroscience and music therapy together. We are working with this at the University of Bergen also. Music therapy's social orientation reminds us about how the brain is not just a controlling system, but exists in an embodied form, embedded in sociocultural practices.

How do you involve the "ordinary staff"?

Cross-professional collaboration is central to music therapy. Patients often use music therapy in combination with medication and/or verbal psychotherapy, so music therapists should participate in the cross-professional treatment teams. Also, music therapists often do therapy sessions together with colleagues from other professions, for instance in various forms of group therapy. There seems to be a musical 'ripple effect' in a ward or organization too, because patients often want to share their music in various ways. There are studies indicating a 'bystander effect' on the staff's morale, stress, compassion fatigue, and so on.

In times of austerity, can we afford unconventional therapies?

In times of austerity, it is highly pertinent to explore the potentials of therapies that can demonstrate complementarity, acceptability, and sustainability. The hospitals that have been most successful in implementing music therapy, such as Haukeland University Hospital in Bergen, have prioritized this even in clinics with a very challenging financial situation. Times of austerity invite innovative thinking in the health care services. There is currently an enhanced interest in health economics among music therapy researchers as well.

How is music therapy doing in Norway as compared to other countries, in Scandinavia, the Baltic region and the rest of Europe?

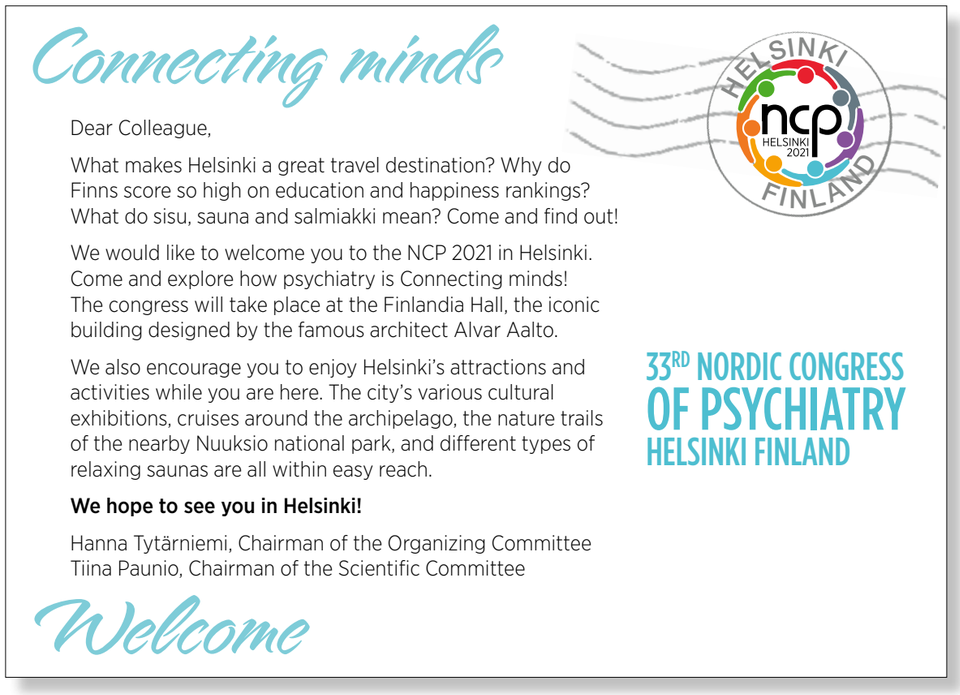
Music therapy is developing rapidly in all the Nordic and Baltic countries, and education programs have been established at the Masters level, which has become the norm in Europe. Two characteristics of Norwegian music therapy have been its broad research orientation and its strong social orientation. After 2013, when recommendations of music therapy started to emerge in national guidelines for treatment, we have also worked systematically with national implementation. In Bergen this led to the creation of POLYFON Knowledge Cluster for Music Therapy, coordinated by the University. Almost 20 partners are involved, and they strengthen each other. The health care services need research collaborators when implementing a new practice, and the research centres need contact with practitioners and service users in order to develop relevant and solid research.

Can the introduction of music therapy tell us something about physicians' reception of new knowledge in "their own domain"?

Some people embrace new ideas and practices quite quickly, others need more time, and some hardly ever change their minds and habits. I don't think doctors are different from most people when it comes to this, but they are different from most people in that they have powerful positions in the health care system. How physicians relate to new knowledge is vital to what happens to music therapy. When working with the knowledge cluster POLYFON, I've been impressed by the number of physicians who are supportive. This is encouraging. Health is a human right, and it's crucial that we work together to develop high quality services. ■

Submission of proposals for Symposia and Round Table Sessions will be open from June 1st to August 31st, 2020.

Submission of Abstracts will be open from October 1st 2020 to January 15th 2021. More information at www.ncp2021.fi



"Proficient psychiatrist produces psychopharmacological piano-music"

Karl Lundblad

Andreas Fröjdmark is a composer, pianist and resident in psychiatry. His album was recently released and has the name "Medications" with hit songs such as "Clozapine" and "Oxazepam (morning dose)". He most recently performed at the annual resident-conference january 2021.

Where do you work currently? Do you have any current field of interest within psychiatry?

I work as a resident psychiatrist in Gothenburg, with 1.5 years left for the specialist degree. Psychiatry is a huge and versatile subject and all its parts interest me deeply. But if I must choose one topic, I would say the conversation and the meeting.

How do you combine your psychiatric life with the composing and practice?

I compose the best when I work the most, as that gives me experiences to reflect and meditate on. Playing and composing is all relaxation for me, something I need to do to feel good. Therefore, it is not difficult to find the time for it and use it constructively. I believe the music makes me a better psychiatrist and vice versa.

Are there any certain circumstances, experiences, meetings or emotions from your line of work that comes to mind in your music?

Many! The music is created as a reflection on mental health and illness, based on my own experiences as a doctor, but also as a patient and a relative.

The works Medications brings my mind to certain clinical situations, diagnosis etc. Is this how we should interpret the music?

The album is an artistic project without any targeted messages or statements. It is not written specifically for or about anyone and it is not really about specific situations. My hope is instead that the listener will find their own meanings between the drug names and the music. I myself have discovered new sentences and metaphors over time, but even though I am the one who composed the music, my interpretations are no more valuable than anyone else's. The meaning of music is created in the meeting between creator and listener. I appreciate your interpretation and would personally fully agree, some songs bring specific meetings to my mind. But next time I listen, it might be something else that pops up.

I find all works of Medications including Clozapine quite hopeful, with hints of melancholy. Would you agree?

I have tried to open up the music to all the emotions that might exist. In psychiatry, you encounter feelings that are rarely expressed in other contexts, for example emotions and thoughts dealing with the very meaning of life. I wanted to include them in my music as well. It would have been impossible to work in psychiatry without believing in change and to write music about those experiences without a sense of hope. It wouldn't surprise me if that were also heard in my music.

Andreas Fröjdmark - Medications can be found at https://open.spotify.com/playlist/3B8O19TC0gUSPGXccbg6nU

Do you have any favourite/"hate" medications in your clinical practice? Does this show in your musical work?

Interesting question! You can of course never blame medicines for being something; they are simply what they are. It is instead our job as physicians to understand their functions and to use our knowledge in line with a well thought out medical plan and process. If it fails, there is a great risk that drugs will do harm instead of benefit, where, of course, different drugs have the potential to do different scales of damage. Sometimes I feel a frustration over how benzodiazepines are used, often without any plan of how to phase them out. The fact that oxazepam obviously is administered as fixed dose on the album (morning and evening dose) could maybe be seen as a subtle hint of that impression...

So what plans are there for the artist Andreas Fröjdmark at the moment?

I will perform in a church in Sweden, Eksjö during february, and I am currently planning on performances in Stockholm and Gothenburg. ■

Karl Lundblad
Resident in Psychiatry, Stockholm

Contagious disease and visual representations

Øivind Larsen

Ravaging diseases are reflected in history through visual arts – drawings, paintings, sculptures, architecture, and monuments. Such pieces of art range from contemporary documentations of death and suffering, to commemorate the victims of a disease, and over to the use of historical epidemics or other frightening disease as a basis for allegoric works. There also is one category where artists' works have a defined function in the fight against disease, e.g. to convey prayers and calls for help and cure to forces above, or to prevent new attacks.

Øivind Larsen
professor emeritus of medical history
University of Oslo

In 2020, the Covid-19 epidemic suddenly awaked a new public and professional interest in the infectious diseases of the past. Media plunge into the abundant literature on the topic, and use the work of old artists as illustrations. Scaring scenes have been depicted, which underscore the seriousness of the 2020 situation for the modern population.

However, what can we learn from these pieces of art?

A glimpse of a horrible past

In the small and hidden Christ churchyard in central Oslo, between the colonnades of the former Deichman's Library and the Church of Margareta, there is a discrete and humble monument (figure 1). A holy cross on the top and a sober text remind us about the plague epidemic of 1654. The block letters engraved into the stone praise Jesus Christ for his revival of those who have passed away. In addition, and in accordance with old traditions, the monument mentions the names of the people who had erected it. The text says:

JESU CHRISTO TIL ÆRE SOM OPUÆCKER DE DØDE ER DENE KIRCKEGAARD I DEN STORE PESTIS TID AO 1654 ANORDNET AF HANS JACOBSØN SCHØRT K.M. OBERSTE OC COMENDANT PAA AGERSHUS DA I STATHOLDERS W.H. GREGERS KRABBIS FRAVÆRELSE I SLOTSLOV FORORDNET EFTER BISPENS M HENNIG STOCHFLETS BEFALING AF SOGNEPRESTEN H. MICHEL PEDERSØN ESCHOLT DEN 18 OCTOBRIS INDVIET. VED TØYHUUSFORVALTEREN CAPT LAVRITS PEDERSØNS INSPECTION INDHEGNET. DEN FØRSTE HER VDI BEGRAFVEN VAR ARNE SIVARDSØN SOLDAT AV WANG SOGN.

Here, in the Christ churchyard, and in the nearby Vaterland cemetery, 1523 victims were buried in four months. That made up around 40 % of the resident population of the city of Christiania (now Oslo), a toll which puts a perspective on later epidemics. The disease in 1654 was a plague outbreak, a similar deadly blow against the society as had been the similar rat- and flea-borne Black Death infection three hundred years earlier. Bubonic plague killed almost everyone who was hit, and a lung attack meant a 100 % lethality. The low-key memorial stone on the Christ graveyard tells about a situation which is quite different from the indeed severe Covid-19 attack of 2020.

Endemic diseases and epidemics

The contrast between the health risks of 1654 and our time could not have been greater. In the Nordic countries many of the most important contagious diseases since then more or less have disappeared, or at least faded in public and individual concerns, especially in the latter half of the 20th century. The introduction of antibiotics and specific chemotherapy for individual patients was one part of this process, but massive implementation of established hygienic knowledge and increasing social welfare perhaps were of larger importance on population level.

Figure 1: Painting by Hilding Linnqvist from the Spanish flu in 1920, belonging to Moderna Museet in Stockholm, here presented as front cover on the Journal of the Norwegian Medical Association in 1990.

The scaring poliomyelitis epidemic in the years around 1950 may be regarded as the last one in the series of scourges where medical and human minds really were challenged, until the Covid-19 virus started to spread in 2020. From a point of view from medical history, these seventy years may be regarded as a time window when infections by many were considered as a problem of the past.

Figure 2: The plague monument in Oslo from 1654. (Photo: Øivind Larsen 2020)

The history of disease tells about a long series of deadly epidemics from plague in ancient China to modern influenza. In this narrative the Roman Justinian Plague (541-542), the Black death of the fourteenth century, the recurring cholera of the nineteenth century and the Spanish Flu 1918-1920 are core elements. But most countries suffered from smaller epidemics all the time. New diseases were coming in, ravaged the local societies for a while and disappeared. In addition there were waves of well-known endemic infections giving the same effect as epidemics entering from outside, warning the population about the perils of life. For centuries recurrent acute diseases with a wide range of symptoms represented normality.

Infections and metaphors

Until, say, mid-nineteenth century, diagnostics were mainly based on symptoms and signs. Verbal descriptions often are unclear to us, not least because different diseases with resembling symptoms could be present at the same time. However, bubonic plague with its typical appearance was in addition easily recognised because of it's nearly 100 % lethality. So was also Asiatic cholera leading to extreme diarrhoea and the quite

Figure 3: A Danish St. Rochus figure protecting against plague. (Photo: Øivind Larsen)

immediate death of every second patient. The endemic "nervous fever" also stood out; probably Salmonella outbreaks where often as much as one out of four attacked succumbed.

No wonder that the sudden occurrence and the dangerousness were perceived as the common denominator of epidemic disease in cultural impact. "Pestilence" and "plague" became more than specific diagnoses. They became metaphors for evils of the world.

When you walk around in one of the large art galleries, you will certainly find dramatic pictures of epidemics, often named as plague. However, often these classical paintings should be interpreted with abstraction and an eye for metaphors. Perhaps the disease has been used by the artist to tell another story. In the long run the cultural impact of the diseases may have been as important as the immediate death rates of epidemic episodes.

Since the eighteenth century, the history of diseases becomes more exact. Numbers are by now available and allow for calculations of incidence, mortality, and lethality. Computerised studies of Swedish parish registers of the 18th century reveal a spread of contagious disease following traffic on roads and rivers at the slow pace of the communication at that time. Mapping diseases in Norway in the latter half of the nineteenth century gives patchworks of disease surplus, varying rapidly from year to year, and where vicinity to vivid harbours is an important spreading factor. We understand that people of the past were living under a constant threat of swiftly attacking diseases, which on the local level could have health hazards by far *exceeding* e.g. those exerted by the Covid-19 virus.

But was the population alerted? Did the generally brittle health situation precipitate corresponding cultural impacts? The short answer to these lengthy questions is that people seem to be used to the health insecurity and to the fact that life had an inherent calculated risk.

This is also interesting because health conditions of the past which today would have been regarded as highly unacceptable, for long seem to have been tolerated. Disease and death were more parts of daily life. Even serious health issues, as recurrent, dangerous contagious diseases, were not so spectacular that they attracted artists' interest.

Disease in visual arts

A shift in disease perception entered artists' scope of motives in the 19th century. In literature and visual arts the individual human being comes more in the foreground. E.g. in Norway, tuberculosis was widespread and had a clear social profile. The multitalented and influential author and painter Christian Krogh (1852-1925) presented his portrait "Sick girl" (1881), showing a dying young girl. This is not only a picture of a suffering young girl on her way to leave her life too early. The painting also accuses the society for failing concerns about tuberculosis.

Edvard Munch (1863-1944) followed up with his famous picture "The sick child" (1885-1886). Here, the dying girl is a documentation of what was going on in homes and hospitals all over the country, but also of a plea for compassion.

The emerging interest for disease in arts boosted with the cultural emphasis on the single patients. In 1919 Munch turned to the epidemics and showed his own experiences as a patient suffering from the Spanish flu in a self portrait, sitting quite exhausted in a room dominated by the yellow colour of pestilence and a poisonous green.

One hundred years ago, in February 1920, the naivist Hilding Linnqvist (1891-1984) in Sweden, one of Munch's followers, also was hit by the Spanish flu. He was hospitalised in Sabbatsbergs sjukhus in Stockholm. His painting from the same year "Sjukhussal II" is obviously rooted in his own hospital stay (figure 2). It conveys the ambiguity and feeling of helplessness experienced by the doctor in the centre of the picture, responsible for patients he perhaps will be unable to help.

In Norway, the fear of epidemics is known to everyone through the drawings, paintings, and texts by the painter and author Theodor Kittelsen (1857-1914). From 1896 onwards he worked on the history of the Black Plague. He symbolised the deadly infection as an ugly old woman, sneaking into houses, carrying a besom indicating that all should die. If she had a rake instead, it meant that some in the household would be spared. The book under her arm contained the names of the victims to be killed. Kittelsen's book on the plague was published in 1904. But in the case of Kittelsen, and in other pieces of art of the same kind, the scaring disease was successfully used as a metaphor to depict existential distress. It is not a documentation of a historical situation or of what the artist had seen himself, as by his contemporary colleagues Krohg and Munch.

Metaphors, symbols, and medical function

We understand that how disease has been perceived through the centuries, is a key also for the interpretation of visual arts presenting health issues. However, in a wider perspective and another context, pieces of art can contribute to cure and prevention of disease, especially the most threatening ones, as the epidemics.

In a deeply religious society disease often has been regarded as a punishment from above for sins or deviant behaviour. To preserve health includes obeying prevailing rules for social conduct, and to respect and worship God the almighty. *Therefore* many pieces of art with medical motives have to be interpreted in a religious framework.

This medical function of arts has two aspects. One is represented by e.g. altar pieces to be used for prayers, forwarding needs for healing and for protection against new attacks. The other side is artworks expressing gratitude for e.g. an epidemic which has come to an end.

As Catholic Church practices include worshipping of saints which serve as mediators for prayers, there is a series of saints attached to different diseases. We find several local variations, and many saints can be connected to the same diseases. As an example St. Rochus is often mentioned in connection with contagious disease and epidemics. Figure 3 shows a Rochus figure belonging to the medical historical museum in Copenhagen. Adoring St. Rochus served both as cure and prevention.

In protestant countries the worshipping of saints is not common. Prayers are addressed directly to God or Jesus Christ. This is also reflected in the more minimalistic sacral arts which replaced the rather exuberant Catholic Church decorations at the time of the Reformation. Monuments expressing gratitude for the survival of an epidemic are not often seen. This explains the discreteness of the plague monument erected in Christiania in 1654.

However, one of the most spectacular artistic structures of the world, devoted to the plague, can be seen in the Graben street of Vienna (figure 4). It is a column, richly equipped with sculptures connected to the disease, designed for healing, prevention, and expressing gratitude. In 1679 the Austrian capital was hit by a severe plague epidemic. It was perceived as a punishment for indecent life. Already in the same year Leopold I (1640-1705, Emperor of the German-Roman empire from 1658) promised to erect a plague column if the epidemic ended, and a provisional, wooden column was set up the same year when the epidemic waned.

Figure 4: The plague column of Vienna photographed on a December day of 1984. The numerous allegoric sculptures glow in the floodlight and remind us that our lives are at risk, even in happy Christmas times. (Photo: Øivind Larsen)

To the deeply catholic emperor there existed none of the protestant restraints on artistic visualisation. Work started to construct the permanent and still existing lavishly decorated baroque 21 m high column which could be inaugurated in 1693. The column was a tribute of gratefulness that the evils of the 1679 plague and those of the siege by the Turks in 1683 had been overcome.

Since then the plague column with its cultural and religious allusions has been a central point in life for the Viennese population. In the Second World War it was protected by masonry to avoid destruction.

In 2020 it has been surrounded by candle lights and children's drawings to protect against the Covid-19 virus.

Hopefully it works. ■

Art Against Stigma

Ekaterina Sukhanova

WPA Section on Art and Psychiatry promote an understanding of the dialogical potential of art in order to change the context in which mental illness is experienced and promote reintegration.

Ekaterina Sukhanova
Ph.D.
Associate Dean, City University of New York
Co-Chair, WPA Section on Art & Psychiatry

Art and Psychiatry Section of World Psychiatric Association (WPA)

The Art and Psychiatry Section is one of the oldest Scientific Sections in WPA. The roots of the Section go back to the early years of the Association. The founding World Congress of Psychiatry at the Sorbonne University in Paris in 1950, led by the first WPA president Jean Delay, was accompanied by a well-publicized exhibit of art by psychiatric patients.

Over the decades, the Section leadership included such prominent psychiatrists as Robert Volmat, Vittorino Andreoli, and Carlos Carbonell. Since 2005, the Section has been chaired by Hans-Otto Thomashoff, MD, PhD. All psychiatrists as well as other clinicians or scholars interested in joining the Section are warmly invited to contact us through the WPA Website:

https://www.wpanet.org/sections-1

The work of the Section encompasses multiple disciplines at the intersection of art and mental health. Creative works by patients have long been acknowledged as a key source of information in the diagnostic process. Further, working with patient art may aid the clinician gain a better understanding of the preserved aspects of a patients' personality, beyond the pathological syndromes ("in his or her totality," to use a well-known expression of Jean Delay), and build a better therapeutic alliance. In this way, art is a resource for the clinician in effective planning of specific medical and social rehabilitation strategies.

In addition, Section officers have been actively promoting the use of art in anti-stigma campaigns, such as public exhibits of psychiatric art, which have been organized at many World Congresses of Psychiatry, national psychiatric conventions and other scholarly events around the world. Such exhibitions counteract negative social stereotypes, undermine the cultural mechanisms for stigma and stimulate an interdisciplinary discussion on the origins of creativity.

Semiotic Mechanisms of Art

The still surviving old misconception of psychiatric art as being free from existing conventions, social or aesthetic, is easily challenged in an age when access to the Internet is widespread and long-term institutional isolation is rare. Moreover, it contradicts the nature of an artwork as a semiotic structure.

All art represents a dynamic relationship between following an existing aesthetical norm and deviating from it. Absolute detachment from conventions and norms would bring communication to a complete halt. Art in a vacuum is impossible; in Siri Hustvedt's words, "our visual perception is not solitary but steeped in an intersubjective, shared reality." Art perception relies on a dialogical communication between the artist, the audience, and the cultural tradition that allows for new meanings to be generated.

Art in Counteracting Stigma

In our view, art can the capacity of weakening or disrupting the "vicious circles" of stigma (Sartorius 2000) in two instances. First, the dialectical mechanisms of art may be built upon in order to prevent a marker from becoming associated with stigma. Stigmatization is based on the objectification of the other, that is, denying him or her the right to be an independent agent. It also involves rejection of any new information that may lead to altering the existing constructs. In sum, stigmatization is a breakdown of communication. Art affords us an alternative model in which the other is considered an equal partner.

Second, art allows for critical distance, retrospection, and vast opportunities for individual choice and thus may be conducive to an improved self-image. While allowing for an interaction with the artist's internalized objects, the creative act is also intrinsically linked to abstraction, or the ability to see the universal in the individual. Creative activity can thus be conducive to both individual psychological stability (feeling connected to oneself) and collective inclusion (the capacity to be connected to others).

With its powerful potential for changing both the self-regard of the artist and an externally imposed identity, as André Malraux said, "art is the anti-destiny." The communicative nature of art allows patient artists the freedom to position themselves in the discourse rather than submit to dominant narrative—an experience which is inherently empowering. Seizing the dialogical potential of art, we can help change the context in which mental illness is experienced and promote reintegration. ■

Tracy Reinhardt
Two Poles, 2006, Mixed Media
Private Collection, USA

Reference:

Sartorius N. (2000). Breaking the vicious circle. Mental Health and Learning Disabilities Care 2000; 4: 80.

Interview on Art Therapy with Jonas Audėjaitis and Virginija Adomaitienė

Ramunė Mazaliauskienė

R.M. When you think about psychiatry and art, what is your first thought?

J. A. I would rather change the parts of the question – about art and psychiatry, as all my conscious life I am in arts, and I see its processes from a close distance, but not form the side of medicine. That's why my thoughts about art therapy and psychiatry are only the thoughts of a person who knows the practical side.

Thinking about art and disturbances of consciousness in from of myself I see artists who delivered masterpieces to the world – Mikalojus Konstantinas Čiurlionis, Vincent Van Gogh or Salvatore Dali, or the others that were accepted by the society as "strange" or as people existing behind the limits of the norm acceptable for the society. Their ability to see things in a different light gave us masterpieces that cannot be repeated. They crossed the boundaries of acceptable norms and stereotypes, and in their creations, they represented the layers of the consciousness that still are admired by the world. To create something new, probably, is impossible without refusing to use the decisions already used in all the areas – economics or arts, medicine or engineering. You must have another way of seeing in order to find something new in a place where nobody expects to find something new. Does it mean that a society that is presented with boundaries and which accepts these boundaries cannot generate new ideas? Or in order to create something new and competitive you just have a disturbance of consciousness (mind)? I don't think so, though the history teaches in another way.

For that reason, arts must be an attractive area for psychiatrists, the area where the amount of differently seeing and differently thinking is tremendous. In the times of common wish to develop creativity in all areas arts becomes one of the tools, considering that it can stipulate the generation of new ideas. The role of the psychiatrists in this process is to observe, go deep into the matter of heart and evaluate the boundaries of the norms of the society and to talk about its changes.

V. A. The first though is that there is one more possibility to help a mentally disordered person to return to life – possibility that has nothing to do with usual biological methods used in psychiatry. During my more than 30 years lasting practice of a psychiatrist I had a possibility to "try on" different treatment methods advertised in different periods. But the principle on minimal intervention in mental disorders is meaningful. So, art therapy gives a patient possibility to do something that cannot be done because of the symptoms, of the disability caused by the condition, a possibility to express oneself and to solve personal difficulties. As a psychiatrist and psychotherapist, I am happy to be involved into the preparation and realization of the mutual program of Lithuanian Health Sciences university and Vilnius Art Academy.

R. M. In arts norm and not-norm has different boundaries in comparison with psychiatry. What do you think – isn't it a too complicated challenge for the art therapists who work in the field of psychiatry?

J. A. Yes, it is complicated. To see the deep layers of consciousness born in the [process of art creation and to evaluate is it a norm or not a norm, must be a difficult task for art therapist. I am confident that understanding a personality, using only creation of a person and without a help of psychiatrist or other specialists, is a task hardly to accomplish for the art therapist. Art therapist must involve a person into the creative processes in a correct way in order to achieve the results: satisfaction of a person being able to self-realize in a process of art creation, and to make a primary evaluation of the creations trying to understand the state of mind of the person who created it.

Virginija Adomaitienė

Prof. MD, PhD is a Head of Psychiatry Department of Lithuanian University of Health Sciences (since 2006). Among multiply activities she is a Council member of Vilnius Academy of Arts, and she is involved in education of art therapist in Lithuania.

Jonas Audėjaitis

is a Lithuanian architect, professor in practice of architecture at the Vilnius Academy of art. He participates in a wide range of international and public activities and organizations, such as Kaunas Culture and Arts Council, and in a working group on the listing of Kaunas modernistic architecture as a UNESCO World Heritage site (since 2016).

For an art therapist is extremely important – together with personal qualities – to recognize the art work as a representation of art and be able to evaluate it according criteria of norm, ability to involve patient in different areas of art and find the ones most suitable ways to express oneself for a certain patient.

There are many trends and areas in art, and it is complicated to be an expert in all. Not knowing the concrete field of art, we cannot expect that the art therapist will define the limits of the norm for a concrete patient. In order to achieve professional and exact work of art therapists whilst defining boundaries of norm in concrete areas of art, they need more specialization. At present stage, probably, is hardly possible, yet in the future, when there will be more art therapists it is highly probable.

R. M. Why art therapist could be useful in psychiatry? Child and adolescent psychiatry?

J. A. A person could express his inner state using words, in written form, in bodily language or in sound. Using devices of art – color, line, form or composition – we can also tell a lot about our inner, emotional information. Creation of art is an important result of the process of art therapy, but its value is time used to create it, as well. The birth of the creation of art has its duration in time, it forces to sink into oblivion and meditate in the flow of personal thoughts in order to achieve the result. Probably this time is as important as medication, as ability to sink into oneself in order to achieve the goal distances other problems, allow to concentrate and – at the end – get the satisfaction in the process and in the creation, and to get positive emotions.

So, the importance of the art therapy in psychiatry is due to two aspects: creative process and creation itself. Art therapist has to manage the creative process in time, allowing the patient to be deeply involved in it and express oneself sincerely. That's why hoping

for the positive effect the pedagogic ability of the art therapist to involve the patient into the quality process of creation is a must.

The other part is the result- the creation of art. In such a case art creation or creations become the expression of mental states of a person. Art therapist if he understands professionally the deep signs in art creation and interprets it correctly can help the psychiatrist evaluate mental state of a person.

I believe that art therapist can be useful in child and adolescent psychiatry because of positive emotions experienced during the process while realizing oneself in the creation of art. These emotions are invaluable, and necessary both for a healthy, and mentally disordered person.

V. A. The methods of art therapy can be used for diagnostics, too. The ways of expression and the techniques chosen by the patient tell a lot about emotional state, problems, personal particularities. Art therapy is a part of complex treatment plan. In Psychiatric clinic we had a master work of art therapist Agnė Murauskaitė- Petkevičienė in which she investigated the effect of art therapy on in-patient schizophrenic patients. I was proud to be the leader of her master thesis. Those patients who participated in group art therapy have shown less positive and negative symptoms, less anxiety and depression, better functionality and collaboration. Taking in mind those results I would see a long – lasting art therapy as an important tool to prevent relapse in mental illnesses. But it is more considerations than daily Lithuanian practice.

R. M. What would be the requirements to the psychiatrists and psychotherapists who participate in the process of the preparation of art therapists?

J. A. For me, the representative of the art practice, not medicine, is complicated to answer to the requirements for psychiatrists and psychotherapists who participate in the process of preparation of art therapists. But knowing that most of those who study art therapy are art people, my main requirement would be to show the clear limits of art therapy in medicine. Psychiatrists and psychotherapists must raise art therapists as helpers in a complex process of psychotherapy, but not as a independent applier of methods of art therapy for a patient. Activities centered towards the patient, understanding and treating his mental state is a complex activity where art therapist performs only a slight function. Understanding the limits of the art therapist is a very important part in the preparation, and medical people are responsible for it.

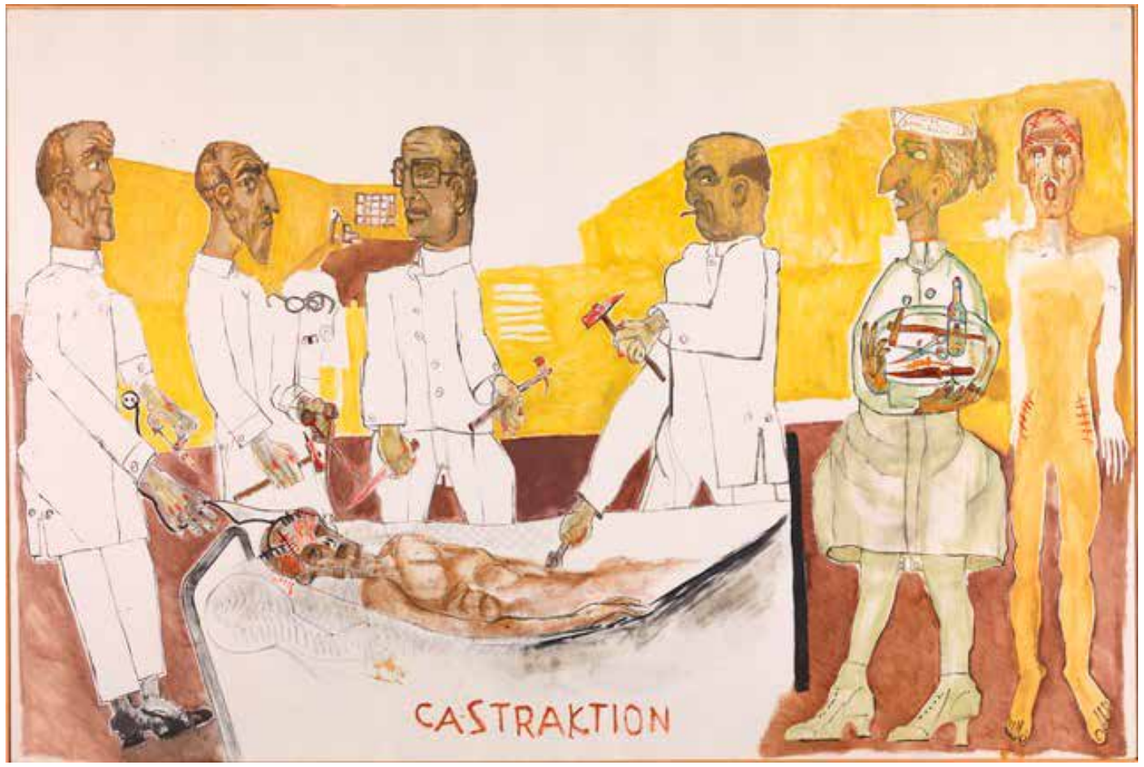
R. M. What is the future of art therapy in Lithuania? In the world?

J. A. Art therapy as clearly state area of activities in medicine becomes increasingly important in Lithuania. In the world art therapy has a longer history and has achieved more results. So, what future? Future will depend on further tendencies of development of the society. But we dare to make a prognosis that as a result of increasing rate of life there will be more and more those who fall off this race and who will search for their inner abilities in art together with art therapist or individually. Art therapist as a part of complex activities in the field of medicine must have clear boundaries while working with psychiatrists. That is why in this area the field of activities will not change much. I believe that their professional abilities will develop. But at the same time, I wish that art therapists will broaden their activities in other areas of health system. Many patients that are treated in the hospitals, have a real time that could be used for creative art activities. It could give a lot of positive moments and possibilities to forget about sufferings for them.

V. A. Today both in the world, and in Lithuania many art therapists work in the areas of health, psychosocial rehabilitation, educational areas, and in the institutions that are involved in these services. Art therapy is widely used in Lithuanian health care system, not only for mental disorders, but also for chronic somatic disorders. The perspectives of art therapy in Lithuania have to do not only with the needs, but with possibilities, too. Decisions about the mental health services are made by health politicians who uses the data of evidence-based medicine. So, I think that investigations of the effect of art therapy for personal health and mental health are essential, and they must appear not only in scientific data base but must be used to educate the society in order to form the need for art therapy. Psychiatric clinic of Lithuanian Health Sciences university is collaborating with Vilnius Art academy; today three interdisciplinary projects are performed. ■

The patient who spoke back - Bendik Riis' painting *Castraktion*

Jon-Ove Steihaug



Psychiatry has a long tradition of interest in art, often due to the idea that artistic expressions and creative processes give insight into the human psyche. One has also found a diagnostic potential in patients' artistic expressions. The interest in patients' drawings may be traced back to the early 19th century, with the establishment of the first asylums being a decisive institutional prerequisite. One of the earliest collections of patient art is to be found from the 1830s at the Crichton Royal Hospital in Scotland , where a physician kept paintings and drawings made by psychotic patients. The French psychiatrist Paul-Max Simon (dubbed "the father of art and psychiatry" by John MacGregor) was the first to make a more com-

prehensive attempt at interpreting patients' pictures. Probably the first public exhibition of patients' art was arranged at Bethlem Hospital in London in 1900, when around 600 works were displayed in the hospital's common area. The French doctor Auguste Marie opened his "Musée de la folie" at the asylum in Villejuif in 1905, and this collection was later transferred to the so-called *Art brut* museum in Lausanne. As we see, it is – not surprisingly – the *psychiatrists' tale* of the patients' creative expressions that has dominated.

This makes it even more interesting to meet a patient and an artist who speaks back to the mental health institution through his art. I will focus on one specific work by the Norwegian artist Bendik Riis (1911–88) from Fredrikstad in south-eastern Norway. He was admitted to Gaustad hospital in 1946 before going into private care at a friend's home on the island of Malmøya in the Oslo fjord in 1952. Riis was declared without legal capacity for the remainder of his life, and from the mid-1960s he lived in the psychiatric nursing home Rishaugen near Halden, close to the Swedish border. During this period he was at his most active exhibition-wise, and in due time this gave him substantial recognition as an artist. In 1984 Riis was the Norwegian representative at the Venice Biennale.

The painting presented here carries the title *Castraktion* (a more or less willed misspelling of "castration", which in Norwegian is "kastrasjon"). Riis painted it in the late 1950s and it was shown for the first time at his exhibition at Fredrikstad Art Association in 1961, together with several similar motifs. The pictures obviously made a very strong impression on the audience, and as one newspaper wrote: "There is an immensely horrific, condensed effect in these eerie and weird caricatured portraits of doctors and nurses, the likes of which one has hardly ever seen" (Demokraten, 2 October 1961). The painting is monumental in size, 200 x 300 cm, and it virtually screams at us. If you take a closer look, you will see that various details have been placed with extreme precision.

The blood red inscription of the word "CASTRAKTION" gives one a first unequivocal message about the depicted scene. Written in large and uneven letters, the word is centrally placed low on the canvas. We are witnessing a bloody and violent maltreatment, both literally and figuratively. One patient lies on the table while the one on the far right has already had his treatment. The colour of the inscription is reminiscent of coagulated blood. The same colour fills the painting's lower half – the "floor" on which the figures are standing – so the entire scene seems bathed in blood, and the colour is repeated to describe the stiff and motionless patient lying there. Further into the picture space this brown hue flows like a sewer around a toilet bowl, giving associations both to blood and excrements. The hospital window at the end of this "inserted" space points towards an outside world – at the same time an exit and a barrier.

The depicted space is both limited and boundless at the same time. On the one hand there is a defined *geometrical* depth (given by the floor and the bed's perspectivical headboard); on the other, an *amorphous* space where this structure collapses. This is caused by the yellow background building up behind the standing figures, like elongations of the various directions of their glances, and furthermore by the distorted doctor figures dressed in white. A further dimension of space may be found in the white, unpainted *canvas surface* which is visible in parts of the motif. The picture is concentrated around a horror scene that is blinded into white nothingness. This could be seen as an echo of the castration motif, which – in addition to the molestation itself – is a tale of extinction and death in a broader sense. The intensely present *whiteness* becomes a carrier of the very character of the asylum and hospital – the white walls, the white sheets, the white doctors' coats, the nurse's uniform.

Besides the blood-coloured brown and the boundless white, the dirty yellow constitutes a third colouristic component in the painting. Yellow may be tied to urine, in the same way that brown reminds us of blood and excrements. Together these colours charge the picture with associations to something bodily nauseating and to odours. In a symbolic way, yellow also refers to the fake, evil and poisonous, and it is therefore commonly used in hospitals as a sign of contagion. Like white and brown, yellow functions as an affectively charged "hospital colour" on several levels. Prior to any tale, the colours convey something absolutely essential that grasps hold of the beholder's body, while at the same time they organise a diverse pictorial space.

Castration refers to a surgical procedure through which the sexual glands are removed, either in the male testicles or in the female ovaries (or correspondingly in animals). A parallel procedure is sterilisation, where one is deprived of fertility but without the production of sexual hormones being affected. Both castrations and sterilisations were performed at Gaustad hospital, so in this respect the artwork is historically correct. Besides castration, the motif explicitly refers to numerous other forms of "bodily treatment" commonly given while Riis was coercively held at Gaustad. These included shock treatments such as insulin injections, electroconvulsive treatment and lobotomy. The depicted surgical instrumentaria are directly linked to these types of treatment and how they were performed. We see syringes, an electrical wire attached to the patient's head as well as piercing tools, knives and hammers. Lobotomy was also called "the white cut" because it implied severing the frontal lobe's white matter, a feature that gives the painting's pervasive white an even more charged and terrifying colour in this context. The blinded eyes of the two victims bring this multiplex "castration" to a visual level, where the castration theme is explicitly connected to a question of sight and visibility.

In contrast, the doctors' stares are sharply marked in the painting – they constitute a kind of deformed figures of power. Their defiguration may also be seen in analogy to the mutilation experienced by the two victims. In this way the perpetrators and the victims may be seen as mirroring each other, implying that the borders between them are not totally unambiguous. Riis has caricatured the features of doctors he knew at Gaustad, so the painting is clearly addressed to specific persons whom he wished to degrade. Their faces are painted in dirty brown nuances, and the swarthy, coarse and distorted features and the dark, ugly piercing glances portray them as sinister, crooked and evil. The half-smoked cigarette in the tightly closed mouth on the right underlines the figure's despicable and gangsterlike character. Close to one of the figures on the left we see a skull wearing eyeglasses. It belongs to a network of small skulls dispersed in the picture – on the many coat buttons, the electrical sockets, etc. In this way countless death glances are inscribed into the picture, immersing it in a massive death motif. The two patients' faces also resemble skulls.

Other details of excess are the many wounds which dramatically underline the violence of the action displayed – all the red sutures, the needle marks and the blood running from the eyes, complemented by the blood-stenched stab weapons, syringes, hammers and scissors. All this shows us how the bodies of the victims are opened, invaded, molested. The use of blood, wounds and weapons connects to a Christian iconography of suffering, as we know it from depictions of the crucifixion of Jesus – the wounds from his crown of thorns, lance wounds and flogging – or from the suffering of the martyrs.

The lesions and the blood may be understood within a conventional frame, while at the same time an affective and physical element points to how the body is perforated and invaded. The way in which the red syringe marks and the pointed instruments flourish throughout the motif carries its own effects.

This work belongs to a series of psychiatry motifs painted by Bendik Riis in the late 1950s, motifs of victimisation which express a trembling accusation towards psychiatric treatment at the time. In an overstated way it also opens for another, quite different perspective of interpretation: Its graphic horror may be discussed as a form of phantasmic staging of the concept of "castration" in psychoanalytic theory, depending upon which understanding of this complex notion one might choose. In this perspective, the painting may also be seen as a kind of meta-painting, an allegory of psychoanalysis. ■

Finns bild Jan-Ove Steihaug?

Jon-Ove Steihaug
Director of Exhibitions and Collections at the Munch Museum in Oslo.
He finished a doctoral dissertation on Bendik Riis in 2008, and has curated two retrospectives of his work - at Galleri F15 in 1997, and at the National Museum in Oslo in 2009.

The art of the mentally ill

Karin Garde, Anne Dorthe Suderbo

Are the works of art of the mentally ill inspired by something mythical and different from those of the non-mentally ill?

Nils Lindhagen asks this but emphasizes that for some artists their motives are inspired by things experienced. Common conditions for mentally ill artists of the older generation were the restricted surroundings and the lack of stimuli from the outside world resulting in stereotypical behavior. However some patients remained original and innovative, despite their monotonous lives.

In 1919 professor of bacteriology, C.J. Salmonsens (1847-1924), started a debate, being the first to use the concept dysmorphism about the morbid tendencies he saw in the development of modernistic art with its veneration for ugliness and deformity. Others, e.g. professor of psychiatry, Hjalmer Helweg (1888-1960), objected and stated: »If you want to study art, study the picture. If you want diagnostic assessment talk to the person."

Many artists show an interest in the art of the mentally ill. Jean Dubuffet (1901-85) used the expression l'art brut, the unspoiled art, without restrictions. Also, the Danish art group Cobra found interest in hospital art, which could also be called outsider-art, and with the exhibition "Outsiders" at the Danish art museum Louisiana in 1979 many people became aware of the fantastic work created outside the established artistic world.

Lindhagen finds that, in principle, the experiences of the mentally ill, which inspire their art, are understandable if you contemplate their backgrounds and the imaginary world behind the artistic products.

The psychopharmacological development in the 1950ies has been suspected of inhibiting creative activity, as medicine may reduce emotions. Yet once the anxiety is reduced it may become easier to describe the inner world.

Sct. Hans Hospital – today Psykiatrisk Center Sct. Hans

Over the years several artists have been admitted to Sct Hans Hospital – formerly the largest Danish psychiatric institution. Among them:

Karoline Ebbesen(1852-1936)

In 1884 she was admitted to Sct. Hans, psychotic, confused, erotically excited and diagnosed paranoid schizophrenic. She remained there until her death, receiving no medication in her manic, erotically excited state with completely daft speech. The doctors described her work either condescendingly or as wonderful polychrome pieces, and today the medical reaction to her creativity seems limited. However, she became creative during her illness and art filled her monotonous hospital life with contentment.

The Glazier (1878-1955)

A highly appreciated artist by the Sct. Hans Hospital's Museum is Harald Martin Larsen, called the Glazier – due to his profession. He was admitted at 40 years old, delusional, hallucinated and overwrought. Diagnosed as schizophrenic in 1921, he was transferred to another ward and subsequently described as quiet and introvert. This taciturn, isolated man created breath-taking pieces of art: Drawings, glass-mosaics, paintings and sculptures. Starting with drawings he moved on to paintings in lively colours, and phantasy landscapes. In the 1930ies the Glazier shifted to symbolic compositions with naïve scenes or painted the other patients in the hospital vegetable garden. Some pictures were given beautiful frames in his very personal mosaic-technique, using glass-pieces or other materials he collected.

The Glazier perceived his work as a duty, in the service of mankind. In late life he became more extrovert, working increasingly inspired by the environment which he gradually adjusted to. This is unusual and in contrast to what is generally said about psychotic painters: that they create for themselves only, out of an inner force without thinking about the viewers – this is unlike the Glazier.

The Glazier

Wiliam Skotte Olsen

Some of his works were part of the first official Danish exhibition of psychopathological art at the "Kunstnernes Efterårsudstillingt" in Copenhagen 1944. In 1979 he was represented in the exhibition "Outsiders" and later some of his works have been exhibited in several exhibitions in Denmark and Germany.

Wiliam Skotte Olsen

(1945-2005)

Skotte was educated at the Copenhagen Art Academy, 1965-70. He enjoyed life unfortunately also with LSD, and he developed ideas about Mars-men invading our world.

In 1975 he spotted what he interpreted as a spaceship that he, for altruistic reasons, ignited. It turned out to be a tent with sleeping children and consequently Skotte was sentenced to imprisonment. However in 1976 he was transferred to Sct. Hans Hospital.

Skotte recovered from his abuse but he became very secluded and painted intensively, over time increasingly stereotypical, with motives of extinguished faces with empty eyes and hanging arms. This was far from his early works of daring colour combinations and enigmatically dreamy scenes. He was admitted several times, living totally isolated. To Skotte art was his lifeline to the world and reality. Today his works are sold at distinguished auctions.

Nikolaj Petersen

Nikolaj Petersen (1973-)

Nikolaj Petersen became mentally ill at 16 years of age and has been in treatment for years. He now lives with wife and children in Copenhagen. His creativity comprises paintings drawings and poetry. When the hospital celebrated its 200-years anniversary Nikolaj had an exhibition where he described his works "It is not nice, this is not done to be provocative, but mental illness is not nice or beautiful comparable to a waterlily or a sunset." Further "When I show you how horrible self-harm is, I no longer need to do it even if it is in my thoughts". This is one of many examples how expressing oneself becomes a protection against intrusive thoughts.

Anne Dorthe Suderbo
Curator Sct. Hans Hospital's Museum

Karin Garde
MD, consultant Sct.Hans Hosptial

We hope that access to creative activities will become available for psychiatric patients. Painting does not cure you but promotes concentration and this may act as a protection against intrusive emotions and may ease recognition and entry into community-life. ■

NILS LINDHAGEN. Carl Fredrik Hill.
Sjukdomsårnes konst. Nils Lindhagen
og Bernces Förlag, Malmö,1976

NILS LINDHAGEN. C.F. Hill ser på
Roskilde. Agrippa – psykiatriske tekster 1987;
9: 5-28

Visions of beauty

- the concept of the schizophrenic artist

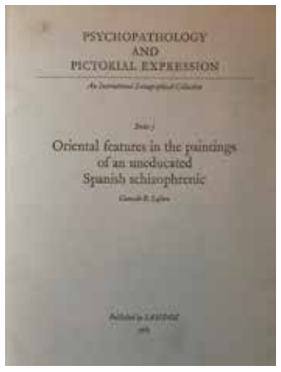
Philip Brenner

The artistic expressions of individuals with psychosis have fascinated mankind since before the birth of psychiatry. But is artistry on a high level really compatible with our current understanding of schizophrenia? Reviewing famous cases may provide clues to the mystery.

Philip Brenner
MD, PhD
Centre for Pharmacoepidemiology, Karolinska Institutet. and Unit for Anxiety Disorders, Psykiatri Nordväst, Stockholm

Not too long ago, I was celebrating the birthday of one of my best friends when, unexpectedly, his father – a retired pediatrician and academic – bestowed me a gift. He was in the process of "death cleaning" - this uniquely Nordic habit of going through one's belongings so your loved ones will be spared this after your passing – when he had found a few publications that he thought would interest me both as a psychiatrist and an individual.

The four well-preserved portfolios he handed me were titled "Psychopathology and Pictorial Expression – An International Iconographical Collection", and were published as a much larger series by Sandoz in 1963-65, apparently as part of the marketing campaign for Mallorol (thioridazin; finally discontinued in 2005 due to risk for severe cardiac arrhythmias and death). An inlay of the portfolios displayed the text "Mallorol – facilitates rehabilitation", and then, in Swedish, "Suppresses Psychotic Symptoms Without Inactivation".


PSYCHOPATHOLOGY
AND
PICTORIAL EXPRESSION
An International Iconographical Collection
Oriental features in the paintings of an uneducated Spanish schizophrenic

The production quality of these portfolios was far from the paper pamphlets, plastic pencils and rubber stress-relief balls that we are used to today as gifts from the pharmaceutical industry. Each folder contains beautiful reprints of pieces of art by artists who are also psychiatric patients, with comments from (supposedly) internationally leading clinicians and researchers in the psychiatric field. An example is "Oriental features in the paintings of an uneducated Spanish schizophrenic" introduced by a Dr. Lafora in Madrid, consisting of fifteen prints of oil paintings by the patient in question (whose name and city and year of birth is by the way clearly disclosed in the text).

The motives and process behind the publication of these portfolios – not to mention the statements about Mallorol – could alone be the topic of quite an extensive essay. Here, however, I will briefly expand on some thoughts that these portfolios inspired on the historical concept of the mentally ill artist, and the "schizophrenic artist" in particular.

Before the beginning of the history of mental illness as a medical concept – a development parallel to the emergence of alienists (later called psychiatrists) – humans who developed psychotic trait were likely considered to be associated with otherworldly abilities. Whether prophetic and visionary, or possessed by spirits or demons, it is not unlikely that some of the descriptions of extraordinary individuals in religious and mystics texts throughout history were written or inspired by persons with psychotic disorders. The renaissance was a period of clarity and sobriety, but as the centuries progressed, and romanticism became the leading movement in the arts in the late 18th century, emotional currents, visions and experiences on the fringes of sanity became highly regarded sources of inspiration and clarity.

With the rise of psychiatry in the 18th and 19th centuries, however, similar phenomena were instead increasingly regarded as symptoms of disease - insanity. The asylums that existed in earlier ages, often run by religious institutions, generally cared for people whose behavioral abnormalities was too severe, e.g. violent, to be cared for by the family or the small community. With the advent of new, state founded asylums based on the model of Pinels Salpêtrière there were more space for committing people with less severe symptoms, who may had already had had a function or impact on society and who actually had prospects to be rehabilitated. Asylums were now, at least in part, hospitals.

The concepts of "diseases of the nerves" and "degenerative disease" were gradually expanded in the 19th century to more subtle behavioral deficiencies. Members of the bourgeois and intellectual classes - not to mention artists - who suffered breakdowns or mental maladies were increasingly hospitalized, often recurrently and in some cases or permanently. A famous example would be Vincent van Gogh (1853-1890) who was self-admitted to asylums for various periods before his suicide. Swedish national poet Gustaf Fröding's (1860-1911) years at different institutions in Sweden, Norway and continental Europe due to alcoholism and nervous problems coincided with some of his most esoteric and mystical works.

However, the concept of the schizophrenic artist had not yet been born. The foundations of the diagnosis of schizophrenia are rightly attributed to Emil Kraepelin (1856-1926), whose meticulous case studies revealed two basic patterns of chronic mental illness; the manic-depressive, which was fluctuating, and *dementia praecox*, which was chronic and deteriorating. Patients with *dementia praecox* were

infinitely different from the artists who spent periods at mental institutions before returning to their other lives; they were instead gradually losing their mental and expressive abilities, increasingly displaying "negative", blunting symptoms after the often chaotic initial years of the disease.

An expansion of Kraepelins mainly bio-medical view on the disease came in the early 20th century when the neuropathologic view of psychiatry was gradually replaced by the psychoanalytic. The actual name schizophrenia was famously coined by Eugen Bleuler (1857-1939), who advocated the term in favor of *dementia praecox* as he considered the disease chronic but not neurodegenerative. Bleuler, as most of his peers, was heavily influenced by the psychological conceptualizations of analytic theory. A chief view was that a central process of schizophrenia was the splitting of intellectual and emotional capacities, hence the name - schizophrenia is derived from the Greek words *schizein*, splittling, and *phrenia*, mind.

Bleuler and colleagues also believed schizophrenia to be much more common than previously believed. A large number of the population could have the "latent" or "simplex" forms, and the disease could also be recurrent with periods of substantial improvement. This opened the door for an extensive increase in the number of patients diagnosed with schizophrenia. A famous example from Sweden is Sigrid Hjertén (1885-1948) who suffered from depressions and mental breakdowns from the 1920s onwards, and spent years at institutions under the diagnosis schizophrenia. The last time of her life she spent practically committed - by her husband and fellow artist Isaac Grünewald. She died in the aftermath of a lobotomy procedure.

Hjertén is only one example of patients who would most certainly not be qualified for a schizophrenia diagnosis by today's standards. Her diagnosis of schizophrenia has often been described as a means for her estranged husband Grünewald and the family to remove her from their immediate context, and the same has been said about French sculptress Camille Claudel (1864-1943), who had been the lover of Auguste Rodin.Other examples where irrational behavior, often accompanied with heavy substance use, has been labeled schizophrenia include actress Veronica Lake (1922-1973), writer Jack Kerouac (1922-1969) and Beach Boys singer Brian Wilson (1942-). A modern example would be Swedish artist Anna Odell (1973-) who was committed 1995 during a brief psychotic episode and diagnosed with schizophrenia. She later used this as a basis for her much-debated installation *Woman, unknown 2009-349701*, in which she reenacted the situation and filmed it.

In recent decades, in part due to the introduction of criteria-based diagnoses in DSM-III onwards (1980), schizophrenia has reverted back to Kraepelin's original concept. It should now be reserved for those individuals who have substantial, chronic, often progressing disability and a highly affected level of functioning. The question then remains: Could you not be a successful artist and still suffer from genuine schizophrenia? Does the diagnosis itself disqualify one from being able to express oneself at a high artistic level?

The answer could be yes, and no. Celebrated Swedish artists Carl Fredrik Hill (1849-1911) and Ernst Josephson (1851-1906) both had remarkable artistic careers before they started displaying increasingly irrational behaviors and bizarre delusions in the 1870s and 80s - a time before *dementia praecox* or schizophrenia were known disorders, They were hospitalized and then cared for by family and friends up until their death. Neither one did reach the same artistic heights again. It could well be that artistic ability may be preserved before and in the initial phases of the disorder, but then becomes increasingly affected as negative symptoms increase.

A poignant example to the contrary could be Swedish artist Erland Cullberg (1931-2012), who was diagnosed with schizophrenia in his 20s but kept up his expressionistic painting at a high level throughout many phases in his life. The brother of legendary Swedish psychiatry professor Johan Cullberg, Erland's disease and the treatment regimens he was submitted to admittedly inspired his brother into becaming a psychiatrist and propagating the introduction of community psychiatry in Sweden.

Finally, a much-publicized doctoral thesis by Swedish psychiatrist Simon Kyaga showed in 2014 that relatives of patients with schizophrenia more often have artistic professions than relatives to individuals in the general population. Higher levels of creativity has also been reported among individuals with milder psychotic traits. There are certainly reasons to believe that psychosis and artistry share traits of both genetic and environmental origins. As evidence from history, and the folios from 60 years ago that are beside me on my desk, beautifully illustrate, the concept of the psychotic artist has fascinated, and continues to fascinate, both our civilization as a whole and the psychiatric profession. ■

Grundtvig – a mad genius

Reflections on mental illness and poetry

Per Vestergaard

Denmark's important psalmist, Nikolaj Frederik Severin Grundtvig (1783 – 1872) suffered from bipolar disorder. His disease and its importance for our perception of madness and creativity is discussed.

Grundtvig had (at least) three bipolar episodes. In the first (1810-11) he showed many manifestations of severe depression and what he himself called "my confused thinking". Prior had been years of hypomanic excitation and great literary activity. Following the episode, he had years of alternating mood.

The second episode (1844) with manic excitation developed in relation to a series of lectures, uncensured published by Grundtvig, and marked by his manic disorder with flight of ideas, digressions, and inappropriate erotic attitude. Subsequently he developed a depression with sleep disorder, motoric unrest, self-reproach and religious scruples.

Grundtvigs third episode had a dramatic climax during a sermon in 1867. He was 83 years and very frail. During the 5-hour long sermon he showed manic delusions. The sermon gave rise to public dismay, and the episode is described in subsequent official reports. After a longer depressive period Grundtvig managed to regain sufficient health to continue as a priest.

Per Vestergaard
Professor emeritus, dr.med. Denmark

Grundtvig's genius

Grundtvig's literary production was huge and comprises many aspects. His genius is particularly related to the religious poetry where Grundtvig has produced unique psalms that colour the life in the Danish church, Danish language, educational system and cultural history.

They contain original pictures giving the environment an emotional experience and an intellectual insight. It is characteristic that he wrote an enormous number of boring routine verses leading to a very telling description of the poetic "pearls to be found in a mountain of simili" (Abrahamowitz, 2001). Consequently, his beloved psalms are frequently found in a revised version where the majority of verses are omitted so only the "pearls" remain.

Grundtvig's legacy is related in particular to the psalms and the movements in the life of the Danish church and education. Here his thoughts are

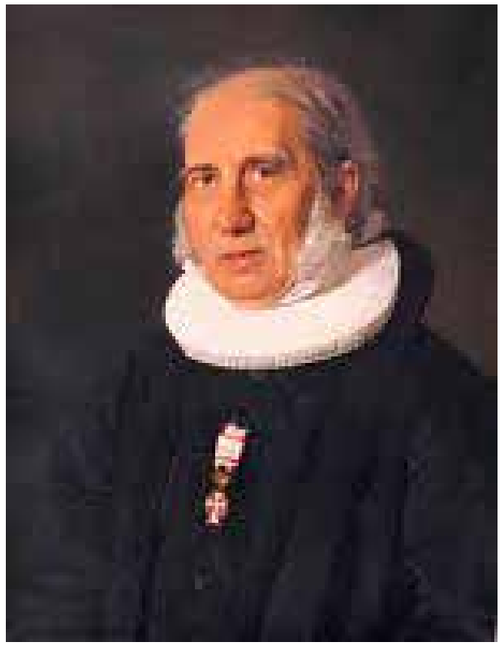
still an inspirational force and the educational work Grundtvig initiated with his ideas on adult education (Højskole) has had an impact around the world. Even today we find in Asia and Africa followers of his principles on enlightenment of the people.

What impact does knowledge about Grundtvigs disorder have today?

No adequate treatment of bipolar disorders existed when Grundtvig lived, but the description of his illness reminds us that illness does not prevent a patient to create things of unique and lasting value. Another lesson is that stigmatisation is not an inevitable consequence - Grundtvig was loved and admired despite nothing was done to hide his disorder. Treatment is not an imperative, on the contrary.

When mental illness and genius are present in the same person – as Grundtvig - one may question whether the disease was a prerequisite for the genius. Humanistic as well as epidemiological and neurobiological research shows a certain but limited syncretism.

Undoubted it serves the mentally ill best to be assessed as ill and when required treated accordingly, irrespective of creative talents. Likewise, it is in the best interest of the creative artist that the product of the creativity is assessed on its own premises irrespective of the mental condition of the creative artist. Under certain circumstances a connection may be found between the disorder and the creative process which may act as a stimulus for the exchange between humanistic and scientific research and contribute to destigmatisation of the mentally ill and promote their life-circumstances. Grundtvig was also here a pioneer. ■



Nikolaj Frederik Severin Grundtvig (1783 – 1872)

Referencer

Abrahamowitz F:
Grundtvig – Danmark til lykke. København, 2001

My mother was possessed

Interview with Peter Øvig

Marianne Kastrup

“My mother was possessed” is a book describing the mental illness of the author’s late mother as well as his own major depression.

Peter Øvig was trained as a journalist in 1987 but already as a teenager started a school journal. Together with Ina Kjøgx Pedersen his debut as author was “Er du da sindssyg” (Are you crazy?) from 1987 describing critically the psychiatric system. Later followed films, a large number of books – portraits of authors and historic books documenting some of the delicate aspects of the 20th century with a focus on what makes human beings cross the norms of society.

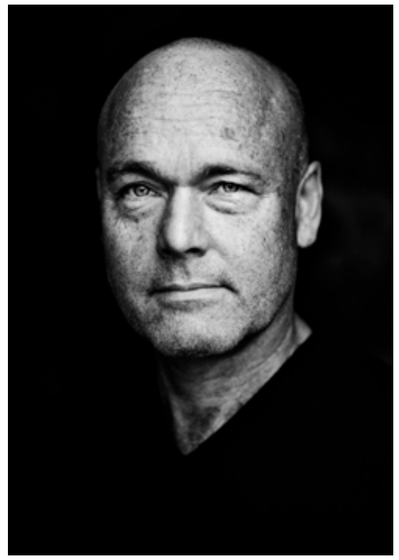
In 2019 he published a very praised book on his mother’s mental illness and his own very serious psychotic depression.

In the end of the book you write that you now have more understanding with a touch of empathy of your mother’s illness.

Today I recognize that my mother might have had a difficult life. She belonged to the generation of women who despite their competencies did not get any professional education. My mother complained, chose the position of victim and I am sure that she had a narcissistic personality, but she may have felt that she never achieved what she wanted. My own severe depression made me realize that she may have been strong-willed and managed to give outsiders the impression that she led a normal life as wife and mother. This I recognize as I also despite episodes of depression was able to perform and fulfill expectations – until my last depression hit me.

Your father seems to have been very loyal towards his wife throughout her illness. Did you and your sister feel he chose side?

My father was a man who rarely talked about emotions. He took side with my mother and tried to soothe the atmosphere in the home, but he never explained to us that our mother had a mental disorder that could explain her behavior. I believe that he felt that love commits you but also that he was avoiding any conflict and as CEO of a hospital wanting peace when returning home.



Peter Øvig
Journalist, author

You have been very critical towards the psychiatric establishment. Was this due to your mother’s contacts with it?

I belong to a generation who was very critical towards the psychiatric establishment and believed in

alternative types of care which is reflected in my first book.

When I experienced my serious psychotic depression, I tried all kinds of alternative treatment but without enough effect. So, I looked for psychiatric help and as the condition was getting worse my partner persuaded me to go to the emergency ward of the local psychiatric department. We were here met with a lack of expertise and understanding combined with a focus on bureaucratic procedures and we left. Later when the condition aggravated, I was persuaded to get admitted to another department where I received pharmacological treatment and as this had insufficient effect, I ended up receiving ECT treatment and improved fast.

Your description of your treatment has a focus on the different therapists. Do you believe that the treatment is dependent upon the individual therapist?

I have a clear feeling that the individual approach is essential. But I do not believe that it is dependent upon the level of education. One of the most emphatic persons I encountered during my odyssey as psychiatrically admitted was a nursing assistant who always saw me as a human being and not just as a psychiatric case. But I have also met very competent psychiatrists who made me revise the views I had in my youth regarding psychiatric care. But it should be emphasized that when my depression was worst, ECT was the only solution.

After that treatment I felt my depression gone but I was told by a psychiatrist that the recovery process is long after a major depression. The initial treatment may result in a limited increase of your energy that it is important to use in order to slowly recover your previous functioning. Unfortunately, many are discharged from treatment too early.

You describe simultaneously contact with both traditional and alternative therapists. Do you think that is a worthwhile approach?

Well it may reflect my old time contact with alternative therapies. But also, a consequence of my desperation. I felt so miserable without any energy that I was looking for any kind of therapy that might help me. I tried healing, massage, etc and none of it helped me in the serious phase. On the other hand, I believe that a mild depression may be treated without any medication.

Being a creative author have you any thoughts about the relation between creativity and psychiatric illness?

I think that we should not romanticize serious psychiatric illness and see mental illness as a precursor of creative activity and that you become more creative of having experienced a psychosis. On the contrary, I see that many artists have a disposition for psychiatric illness and many further have substance abuse. I am convinced that the relation between creativity and psychosis is complex but having been psychotic may enlarge your understanding and field of experience. ■

The story of the family is the history of a nation

Interview with author Einar Már Gudmundsson

Óttar Gudmundsson

Author, Einar Már Gudmundsson received the Nordic Council Literature Prize in 1995 for his book, Angles of the Universe. The book is the story of a young man, Páll, who suffered from serious mental disorders.

In his book, the author follows the character of his book through many years of illness and several admittances at psychiatric wards. Páll´s life is symbolized by various memorable men and women on both sides of psychiatric analysis and mental drugs. Einar often draws humorous illustrations of men and women in our world where the boundaries between mental illness and health are frequently very unclear. As the story progresses, Páll's life increasingly becomes one of monotony and isolation, until he eventually finds himself locked in a world of futility and hopelessness. At the end Páll commits suicide, which in actuality did not come as a surprise to anyone. The Icelandic readers soon realize that Páll was certainly more than a figment in a story by its maker; as Páll was represented in the author's family: Páll was the author's older brother, Pálmi Örn, who suffered a serious mental illness for many years.

How did your brother's illness materialize?

"When he was about 20 years of age we began noticing certain character disorders and fits of rage. He started to drink alcohol which increased and fueled these symptoms. Our parents sought help both through unconventional treatments and with psychiatrists. These were very difficult years for all of us. Pálmi became isolated and trapped in his own world and sometimes referred to himself as the "professional loner". Gradually, delusions and periods of depression became a part of the equation together with periods where his moods would escalate upwards. Pálmi was an artist by nature. He played the drums, wrote poetry, painted pictures, and joined the Reykjavík School of Visual Arts. Pálmi was a highly talented and humorous man, however, his mental condition caused him problems in his artistic expressions. He was unpredictable and could, for

Einar Már Gudmundsson and Óttar Gudmundsson

example, destroy poems by adding crude endings. He never managed to reach balance in his art; instead he swung back and forth in his extremities. His life was symbolized by pain and lack of financial means. He saw himself as a good artist, nevertheless, experienced himself as a loser in the human environment.

How did he affect you?

I was five years younger than him and literally watched him become sick; in fact, watched him disappear to some extent into a world of his own. This generated all kinds of emotions, including sadness, admiration, anger etc. Like Pálmi I started a search for solutions, for example, by joining the Baha'i movement, the Theosophical Society and the organization of radical leftists. The family lived in the outskirts of Reykjavík and I felt as always being able to see, or sense if you will, how Pálmi felt…just by the way the house looked. His impact was everywhere.

How was the situation in the family?

Like Tolstoy said: Happy families are all alike; every unhappy family is unhappy in its own way.

Everyone responded in their own way. Our parents assumed the next-of-kin role, defending Pálmi in every shape or form. Our father would drive him wherever he needed to go. I, however, fled into a world of radicalism and subsequently the world of literature. I did not spend much time at home. My sister sought shelter in her group of friends; however, she never brought her friends to our house. Pálmi was the prince and center of attention What weakened the family also strengthened it. I had a very good relationship with our parents and maybe the interaction with Pálmi made them more tolerant towards me. My father and I were very close. He was a man in possession of such abundance of stories many of which I have used in my books.

How did this end?

Pálmi committed suicide in 1992 and the Angels of the Universe was published in 1993. Writing the book took a long time and Pálmi frequently said that I should write a book about him. I wrote incredibly many parts and tried to experience myself in this world of delusion; the world of the person watching from the outside. His suicide did not come as a surprise to me as his threats to take his own life had been a part of our reality for many years.

How do you want this book to be interpreted?

This is up to every single reader. A motion picture and a play have been written on grounds of the book and the interpretation between those versions is totally different. Many people have come to me because they recognize themselves in the book and feel they were the image of some of the characters in it. I enjoy such approaches. However, the most valuable reaction was of course from the very beginning how people were grateful for the story being told.

One of the most known sentences in the book is *"The Kleppur psychiatric ward can be found in various places"*.

Things are not always how they seem. Superficial happiness does not always tell the whole story. The Kleppur psychiatric ward is quite normal in comparison to many other things. Or, as Pálmi sometimes said: "He who loses his marbles has something to lose".

What about your later works?

Creative writing always provides me with new projects. Mental illness, and maybe even Pálmi, repeatedly appear in many of my works. My role as an author is to convey time; to dispatch the story between the generations. The story of my family will gradually become a story of a nation. A small world is a large world. Such is literature.

Einar Már Gudmundsson
Author

What is your vision of life from an author's point of view?

It is very important that we manage to get out of the format and to examine things from another perspective. Pálmi was criticized once as being lazy and for not working. He said on that occasion: "I have seven lives and it is always Sunday in this one. So, I don't have to work". This is actually a totally new vision of reality. Or, maybe we should say: "Sometimes delusions seem to be correct. There is sense in nonsense." ■

Conclusively, a poem by Pálmi:

The madman says:
"They've
buried me".

Every Sunday
he goes to the cemetery,
placing blooms on the grave.

Poetry and Psychiatry

Ferdinand Jonsson

People say poetry is a set of techniques to get feelings into words. The patterns of words can tell you what is in the heart of others. Like the wonderful verses of Amy Winehouse and Emily Dickinson. Disperse the loneliness.

Ferdinand Jonsson
Consultant Psychiatrist and Associate Clinical director for Inpatient services in Tower Hamlets, East London Foundation Trust.

The connection with psychiatry is there, especially for some of our patients. There seems to be a link between creativity in poetry and mental illness. I have been honoured to listen to some amazingly talented patients at work. But this isn´t really what our work is about? We are paid to help people. However in our field honesty, respect, humility and hope are the cornerstones in serving our patients and their families well. So celebrating their strengths, while getting goosebumps, is not a bad thing.

What about us on the other side of the table? Psychiatry is the most humanistic field in medicine. People with a passion for creativity and art tend to come here. But as ever things are complicated and multidimensional.

I have been asked to try to answer this for myself.

I was introduced to some of the poetic masters through pop music. From there I started to read. I relised that listening to poetry for me, is just pure magic.

So I learned poems. A first aid whenever you need their help and embrace. Then I tried to make some of my own. Sublimation supposedly helps.

Maybe our profession is full of people in the artistic closet? Perhaps, like me, they did not have the courage to pursue a life in the arts?

When organising a poetry evening for the Icelandic Medical Association, this theory was strengthened. We had many great people coming out as poets.

Possibly medicine gave me the courage to keep on writing and eventually to publish? But things are never what they seem. Living abroad, needing tools to manage the complications of a new land. The perceived and the real losses. The turmoils of my life. My homeland.

Checkov said medicine was his wife; writing his mistress.

Psychiatry is about feelings, relationships and words. We listen to real stories. Look for meaning. Read into the silence.

Perhaps some inspiration comes from the countless and somewhat complicated relationships at work?

Then we work with kind people. Some altruistic ones. Even willing to listen to poetry for hours. For me finding a balance between work, life and poetry has been helpful. A pleasant journey.

So maybe being a little less faithful to our work is a way to avoid burnout?

Try to be kind to ourselves and create a room of one‘s own. Take the darkness and the colours of life. Pursue the art we love. Try to create something worthwhile, primarly for ourselves and perhaps for others?

Maybe soothing is the word?

My little room has single words and short sentences and a lot of silence. ■

VEIKINDI	**ILLNESS**
þetta er of	this
langt	is too long
í óbærilegu	in the unbearable
ljósi	light
óvissunnar	of uncertainty
þetta er of	this
langt	is too long
fáir	few
það	will
vita	notice
enginn	no one
mun	will
orð	utter
mæla	a word
nema	but
þú	you
snertir	behold
himininn	the heavens
ég	I will
fer	stay
hvergi	still

SVEFN	**SLEEP**
sef	sleeping
í hægum	in the slow
svala	breeze
undir sumartjöldum	beneath silky
mjúkum	shawls of summer
í sólinni	in the sunshine
er sem syndi	they swim
um meðvitund	through my mind
mína	shadows
myndir úr	that belong
annarra	in the dreams
draumum	of others

Poems for psychiatrists

Esben Esther Pirelli Benestad

Esben Esther Pirelli Benestad
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Specialist in clinical sexology NACS
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A transgifted physician, pioneering in a neighboring field of ours, and an applauded lecturer, Esben Esther Pirelli Benestad, is also a poet.
Many will know them from the son's portrait in the movie "All about my father", but they is also a GP and a professor in sexology.

He says about "theirselves": "A special trait in their work is the use of poetry both in therapy, publications and performances. When entering the field of sexology they made a wov to introduce poetry to sexology. The vow was kept. A curiousity to be mentioned is that EEPB has a small theater in their garden."

This poem was inspired by the fact that we went to Guadaloupe together with friends. Mosty of whom were gay men. The first night we spent in a hotel with paper wall. I woke up at night by the sounds of love from the neighbouring room, and at the same time I heard a sound like a cock crying.

It was delightful:

The shameless cocks

We had all been out, we had food and drink,
Hardly more than we should, - at least so I think.
We struck bed by ten, as did all around,
We fell sound asleep, were for dreamland bound.

The sky was dark, the night still on,
The sounds and lights had all just gone.
Still I woke and rose and caught my pen,
To describe this night so cari-bienne.

It was silent and damp, stuffed with tropical heat,
Some mosquitoes were on to my naked feet.
In the distance faint was a song of sea,
What more I could hear were the breath sounds of me.

Now what time did I have – about two o'clock.
Through the air filled with silence came a sound like a shock
In a night made of velvet form some nameless flock
Rose the fertile cry of a shameless cock.

And as time passed by, he was joined by one,
Close to three, they were four and a cock show was on
And as everyone else held their partners tight,
those shameless cocks stirred the velvet night.

Was it right, was it wrong, - that I cannot tell,
But that cock-made song is a waking bell,
For as sleep should go on like a soothing song,
Those shameless cocks, they cried all night long.

Maybe that is the way of the Southern seas
To have some who disturb, and the rest at ease.
For as birds, iguanas and land-crabs hide,
The tameless cocks set all pride aside.

And when human kinds do for sameness stride,
The shameless cocks, - they will not abide.
They live and they act by their innermost drives,
Thus the shameless cocks live such beautiful lives.

EEPB 1999

This poem is a recent one. It was part of my presentation at World Association for Sexual Health's Congress in Mexico City in October 2019. It is more explicitly personal.

A better world

I have been told I live a sin
By those who claim to know
I should obey what I am in
just be my genitals somehow

My childhood was not understood
They almost took my sanity away
They made me feel like nothing good
until one shiny day

When those who had told lies of me
Who sang the diagnostic song
Who made it hard for me to be
They had been proven wrong

Do I know of their remorse?
No, not one single thing
They should feel sorry – yes, of course
But that's for them to bring

I will go on and live as me
Let love and beauty in
And those who might still disagree
They make an awful sin.

EEPB 2019

Therapeutic Power of Dance:

Development of Dance Movement Therapy in Lithuania

Laima Sapežinskienė and Jurgita Kuliešienė

Foreword by Ramunė Mazaliauskienė
Dance therapy and movement therapy pays an important role in the process of recovery. In Lithuania it has short, yet interesting history. In their article Laima Sapežinskienė – one of the most active promoters of dance and movement therapy in Lithuania - and Jurgita Kuliešienė describes the story – times, people, challenges.

Dance concept and therapeutic power

In each known human culture dance is as a part of religious, social or healing ritual (Waszkiewicz, 2019:6). Typical of contemporary definitions of dance is one by dance historian R. Kraus: 'Dance is an art performed by individuals or groups of human beings, in which the human body is the instrument and movement is the medium. The movement is stylized, and the entire dance work is characterized by form and structure. Dance is commonly performed to musical or other rhythmic accompaniment and has as a primary purpose the expression of feelings and emotions '(Van Camp, 1981). In Western psychology and psychotherapy role of a dance grew when Marian Chance established American Dance Therapy Association (ADTA) and this coincided with Dance Movement Therapy beginning. Dance Movement Therapy (DMT), also known as Dance Movement Psychotherapy (DMP) or Movement Psychotherapy in the UK, offers individuals of all ages and abilities a space to explore what drives them, assisting people to develop self-awareness and sensitivity to others and also to find a pathway to feeling more comfortable in their own skin (Scarth, 2013). DMT is defined by the European Association Dance Movement Therapy (EADMT) as 'the therapeutic use of movement to further the emotional, cognitive, physical, spiritual and social integration of the individual. Dance as body movement, creative expression and communication, is the core component of Dance Movement Therapy. Since the mind, the body, the emotional state and relationships are interrelated, body movement simultaneously provides the means of assessment and the mode of intervention for dance movement therapy' (EADMT Ethical Code, 2010). Payn et al., (2014-2017) reveals the mentioned above widely and in various angles in the movie 'Resilient Lives: Building Strength Through DMT' https://www.eadmt.com/?action=article&id=79

Research of the therapeutic impact of a dance

ADTA, in order to research dance and part of the therapeutic process based on dance, was researching connection between individual emotions expression and movement (Waszkiewicz, 2019:6). Therapeutic power of dance disclosed in the recent DMT meta-analysis (Koch et al., 2019). It is underlined that dance is seen as 'an embodied activity and, when applied therapeutically, can have several specific and unspecific health benefits '. Enaction and embodiment emphasize the roles that body motion and sensorimotor experience play in the formation of concepts and abstract thinking (Koch, & Fischman, 2011). The embodied enactive approach looks at individuals as living systems characterized by plasticity and permeability (moment-to-moment adaptations within the self and toward the environment), autonomy, sense-making, emergence, experience, and striving for balance (Koch, & Fischman, 2011). Meta-analysis (Koch et al., 2019) disclosed the effectiveness of DMT. It was found out that therapeutic dance interventions for psychological health outcomes have the potential to initiate a learning process (body access, interception, insight) that might instigate positive changes several months after the intervention. The permanence of effects depends on the participants' behavior after the intervention, such as revising what they have learned, continuing dance or movement classes, or maintaining contact with the other participants. Results of this meta-analysis suggest that DMT and dance interventions im-

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She got her master's degree in physics in Vilnius university. She continued with her Gestalt Psychotherapy studies in Gestalt Studies Centre of Kaunas. Today she is practising individual, couple/families and group Gestalt psychotherapy, she is involved in "Coaching development" and ICF certified coach, Member of Lithuanian Gestalt Association from 2018.

Laima Sapežinskienė
works at a Laboratory of Behavioural Medicine (Palanga), Neuroscience Institute, Lithuanian University of Health Sciences, Lithuania. She is MSW (Master of Social Welfare), Doctor of Sociology (S05) (Sociology of organization), certified Gestalt Therapist, European Association for Gestalt Therapy (S57- 12), certified Gestalt Therapist, Lithuanian Association for Gestalt Therapy.

Laima Sapežinskienė has over twenty years of experience in patients and outpatient practice working with older children, adolescents, adults and disabled persons for individual, couples, and family Gestalt therapy (including assessments, a range of psychological disorders, parenting evaluations, facilitating divorce and parenting agreements, and relationship issues). Laima is taking part in the research projects dealing with psychosomatic health issues, psychotherapy and dance / movement therapy.

prove clinical outcomes decreases depression and anxiety; increases quality of life and interpersonal and cognitive skills, whereas dance interventions increase (psycho-) motor skills. (Koch et al., 2019).

Beginning of DMT development in the world

Dance as healing art is known from many historic sources of many world nations and modern dance movement therapist profession which includes dance, movement and psychology and therapeutic practice, in the beginning was mainly developed in Europe and North America DMT - one of the four art therapy areas beside art, music, drama and other. Historical roots of DMT are in USA and relate to choreograph and modern dance dancer Marian Chace, who in fifth XX century decade started use DMT. In June of 1942 M. Chace was invited to work with patients in St. Elizabeth hospital in Washington, where she first described the DMT process. M. Chace, M. Whitehouse and T. Scoop spent a lot of years in reflecting the training of DMT and only after that presented information on the professional competencies and skills of the dance specialists required for usage of DMT in psychotherapy. These are observation, interpretation, change of dance elements, e.g., rhythm and space, to satisfy patients' needs. In the early development phase of DMT practice it was influenced by widely recognized psychodynamic psychotherapeutic theories in 1940 – 1960 (Chodorov, 1991). In addition to that revival of nonverbal communication studies in 1960–1970 (Schmais, 1980) and increasing awareness of the need to pay attention to a person's body in case of psychiatric disorders Silberstein (1987) opened the way for the use of other psychotherapeutic theories that focused on the personal growth of individuals, connecting internal mental processes with their social environment. This created the theoretical and methodological basis and allowed the development of DMT to contemporary practice. In the analysis of the methodological peculiarities of DMT it is important to note that dance could not be and has not been applied directly to patients.

Dance movement therapy / psychotherapy formation in Lithuania

As in the world, so in Lithuania, the path of birth and formation of dance and movement as therapy / psychotherapy is unique. Once prof. dr. Ligija Švedienė have told that dance and movement integration to psychotherapy came due to 'dance people ', means those who danced themselves and have teach dancing others. According to her, reading the literature alone makes it difficult to adopt or copy methodologies. According to the professor, one of the first to name not only the educational effect of dance, but also therapeutic dance as a means of treatment, was repeated performers of Lithuanian sports dances and well-known dance teachers and medics dr. Jūratė Norvaišienė and Česlovas Norvaišos. They noticed the healing power of dance very early on and were the first to use dance as a stress-reducing psychological relaxation for the elderly, for example, for patients with cardiovascular problems and being in cardiology rehabilitation. Their first publications on dance use in choreotherapy, sport medicine and body culture were published in Russian language. Choreotherapy - (gr. choreia - circle + therapeia - treatment) treatment by dance of central nervous system, cardiovascular, joints, bones and other diseases; helps to restore after difficult physical and mental work, improves mental health.

Most people came to dance and movement therapy in Lithuania (as well as in the global context) from the modern dance field. Some who are interested in their own development or former dancers who have mastered psychotherapeutic methods, the sciences of psychology, have used DMT to achieve deeper changes in human personality. Others who started using DMT for people with disabilities needed to seek additional medical knowledge as well. Thus, the level of specialists using DMT methods is heterogeneous, characterized by different professional training: from doctors, psychologists, social workers, physiotherapists, occupational therapists to cultural workers, dancers, etc.

Studies of DMT development in Lithuania

So far, both in foreign countries and in Lithuania (where the phenomenon of DMT is completely new) there are not enough research works on dance and movement therapy and the theoretical, methodological and practical peculiarities have been singled out. There is a lack of non-verbal education and counseling services (such as dance and movement therapy) that can be provided to patients when verbal counseling is ineffective. Studies on the DMT topic only start to emerge in Lithuania: social pedagogy analyzed the application of R. Laban's practical experience in students' education (Baneviciute, 2004; 2009); public health education analyzed the effect of dancing on mental disabled people (Liaudinskiene, 2005); G. Karoblis's (2003) doctoral thesis on philosophy summarized the researches dealing with sports dance phenomenology, etc.; B. Baneviciute's (2009) thesis studied dance skills education in early adolescence. The first scientific research is performed on dance impact for disabled individual moving with a help of a wheelchair (Soraka, Skurvydas, Sapežinskienė, 2008; Soraka, Svediene, Sapezinskiene, 2009; Sapezinskiene, Soraka, 2016; 2000). DMT effectiveness for children with autism spectrum are summarized in 2018 in Solveiga Zvicevičienė dissertation 'Education and therapy of children with autism spectrum disorders using Lithuanian dance folklore '.

For example, in the broader context of DMT evolution, it is important to note that in 2008 - 2011 majority of DMT method users and practitioners in Lithuania participated in "Integrated dance psychology and psychotherapy" training program lead by Alexander Girshon - psychology science doctor, dance movement therapist, improvisation teacher, choregraph and creator of the dance movement training program and later, 2011 established Lithuanian dance movement therapy association (LDMTA) in the beginning led by Raimonda Duff, now by - Agnietė Laurinaitytė (www.lsjta.lt). Raimonda, who has a qualification as a dance-movement therapist in the UK, says she believes DMT can be applied to absolutely anyone. And of course, for people who can't express themselves verbally. It is especially suitable for people with intellectual disabilities, autism and the elderly with Alzheimer's disease. It is body language, movement, not words, that can become the way that best reaches them, helps to "unlock" emotions, solve difficulties and improve well-being. Also, depression, addictions, eating disorders and more. problems can be solved using DMT. This type of therapy is also very suitable for children who find it more difficult to describe their condition in words. DMT is for everyone, even the "healthy" as an opportunity to get to know themselves and grow (Duff, 2015). Many Lithuanian DMT practitioners have included dr. Alexander Girshon's four-element dynamic visualization metaphorical technique, based on the body's senses and its internal rhythm, into his DMT therapeutic methods.

The author of the four elements dance method A. Girshon uses the metaphorical technique of dynamic visualization (visualization of movements), based on the sensation of the body and its inner rhythm (Svirepo, Tumanova, 2004). This DMT method covers five stages. The first four stages are dedicated to the journey to the so called four elements world, and the fifth stage is the final and inclusive one. Each stage comprises various dance and movement techniques: 1) keys to the body (the earth element – sensation of own body; the air element – breathing; the water element – flow of blood and other body fluids; the fire element – internal rhythm, e.g., heartbeat, pulse, etc.; 2) visualization of one of the stages in space, using dance and movement; 3) identification with dance and movement expressed by the element; 4) the end of the element expression, gaining awards of the element and corresponding titles; 5) the ritual ending, by saying out loud what awards and titles a patient has acquired. The final part of the session includes the closing dance expressing the combined elements.

One of the films shows a DMT session initiated by A. Girshon's training in Lithuania (Ivanauskaite, 2012a https://vimeo.com/34980292). DMT can be applied to the couple (Ivanauskaite, 2013 - https://vimeo.com/63166166). And another film that opens what's going on in a multidimensional space that uses everything: space, field, movement, sound, body, dance (Ivanauskaite, 2012b - 'Suk į dešinę | Turn Right https://vimeo.com/34980292). "This is what makes me cry…., because it reminds me my experienced reality with many people, adolescents, children, elderly…from 1974 when moving, teaching to feel the dance the same you feel life, when dancing, when living life….'

Laima Sapežinskienė, in developing her dance movement psychotherapy techniques, linked them to the Gestalt psychotherapy paradigm. This direction of DMT development also exists in the world. In Lithuania, Violet Oklander gestalt psychotherapy methodology was adapted not only for children, adolescents, but also for adults without health disorders and in case of physical and psychosocial health problems by gestalt psychotherapist dr. Laima Sapezinskiene, as well as sports dance dancer and dance teacher, gestalt therapy practitioner Daina Milikauskienė and sports dance professional, associate professor Alvydas Soraka. Their DMT journey in Lithuania began in 1997, when Laima and Daina worked with children, teenagers and their parents at camps during the summer in Giruliai and Kacergine. Later, gaining experience from psychotherapists at the Jesuit Institute in Glasgow since 2000 started DMT activities in Kaunas the first 'true DMT teacher', Laima considers a group member who was diagnosed with schizophrenia and who started DMT group meetings when before joining DMT group she either was lying in a psychiatric hospital or spending days observing people in a supermarket. The psychotherapeutic aspects of DMT are related to facilitating the unfolding of each patient's unique mode of relating. By experiencing with the patient, through mirroring, attuning, and creating structures for self-exploration through movement, neither judging nor criticizing, the dance/movement therapist

understands and comprehends, linking present with experience (Koch, & Fischman, 2011). According to Daina Milikauskiene, DMT can help to understand "where you are, where you stand, to feel yourself and your body, to feel nearby, the relationship with yourself, the environment and others, will allow you to discover and try new forms of behavior and movement in a safe environment. And when you feel harmony with yourself, with the environment, with those around you, with your couple, with music, remember those new forms of behavior. 'Take away' your discoveries and test them in your lives, in your relationships with others and with yourself. From 2001 in Klaipeda region in Palanga rehabilitation hospital, Monciskes dare care center, Klaipeda Psychiatry hospital and society, professional sport dancer, associated professor Alvydas Soraka was using dance movement for patients after spinal cord injury. He enriched DMT not only with the application of spontaneous, creative, but also structural dance, using Latin American music, in therapeutic sessions with people with disabilities. From 2002 to 2010 he was manager of dance movement in the organization for people with disabilities 'Likimo laiptai' ("Staircase of Fate")and in 2008-2012 – was a tutor of dance movement therapy course in Klaipeda university Rehabilitation department, Kaunas medicine university (now Lithuanian Health Science university) Rehabilitation department and in Kaunas Kolping University of Applied Sciences Social work department. From 2005, in Kaunas Daiva Liaudinskiene applied DMT for individual with mental problems in Kaunas day care center for young people with disabilities and established dance group „Žingsnis po žingsnio" ("Step by Step"). For patients with mental problems DMT was started to apply from 2001. From 2009 dr. Laima Sapezinskiene started to use DMT in Palanga, Lithuanian Health science university, Institute of Neurosciences in Stress disorders therapy department. Here, people experiencing stress, anxiety, depression, personality adaptation disorders are offered various art therapies in addition to the medication program: not only art, film, bibliotherapy, drama therapy but also DMT sessions.

Closing insight

DMT improves emotional, social, cognitive and physical integration of individual (Grigaliuniene, 2014). It can help people with developmental, medical, social, physical or psychological disorders. First, feelings are stimulated and realized through body movement. Second, dance enables a person to communicate and communicate without words. Third, an uncritical therapeutic environment often results in a reduction in anxiety. Fourth, free movement to rhythm creates joy and pleasure physically and emotionally. It has been determined that modern DMT practice for patients and disabled clients, based on various modern theories, holistically embracing the person's body and mental practical problems, is gaining self-methodological basis and aims to become one of the form of psychotherapy in Lithuania, which can be applied for different patients according to their needs, when verbal therapy is not as effective, or in line with verbal psychotherapy (Sapezinskiene, Soraka, 2016; 2020). However, the most important task is to promote the DMT research validated at the national level, and to conduct the recognized professional training for specialists who provide DMT in Lithuania.

On the other hand, it is could be underlined, that in spite of various paradigms of psychotherapy and DMT, as one of the art therapy practice, therapeutic effectiveness is extracted because in DMT process it is turned to relationship and dance opens personal drama of the individual as his constructed social reality in which old is merges with new and stable parts with constantly changing parts. Quoting Valantiejus (2004:452): 'In the language of the sociology of the art worlds, meaning is unfolded, and the focus is on the context of creation. Any result of 'meaning' is considered an epiphenomenon of the creative process, but not an internal part of the artistic creation or communication between the work and the audience.' ■

Clinical advice on the reduction and withdrawal of antipsychotic drugs

Interview with Jørgen G. Bramness

Ola Marstein

You have recently, in collaboration with six psychiatric colleagues, published a guide for reduction and termination of antipsychotic drug treatment, under the auspices of the Norwegian Psychiatric Association – congratulations!

What made you take this initiative?

There were several reasons for this initiative, political and practical. In Norway the Directorate of Health are given exclusive responsibility for creating and maintaining guidelines for the health professions. The intentions behind such a monopoly are the best: to secure adequate quality of national guidelines. But there are some unfortunate adverse effects. The Directorate is not rigged to produce all needed guidelines, and certainly not to review them and update them when needed. Quite often, we are left with outdated guidelines not serving their purpose. More importantly, the democratic process embedded in the official production of guidelines, e.g. including all stakeholders willing to participate in the process, sometimes makes the guidelines more representative for some special interests, than representing the best practice. Often there is heavy political influence. Too many times Norwegian doctors in general and Norwegian psychiatrists specifically, are mere receivers of advice they do not condone or agree with. Lastly, we wanted Norwegian psychiatrists to take a more active responsibility for the development of their own field. In many other countries physicians themselves produce their own guidelines. Why shouldn't we do the same? A solution to all this would be to take a somewhat controversial field and produce guidelines by psychiatrists for psychiatrists. The tapering of antipsychotic drugs seemed to be a good candidate for several reasons.

What is the group's professional background? (Are you all physicians or even psychiatrists, or do you also include pharmacists or pharmacologists?)

As mentioned above the idea was to make a guideline by psychiatrist for psychiatrists. Having said this, the group consisted of psychiatrists with a broad

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background; at least four having PhDs in psychopharmacology. One even had a double specialty, being both a psychiatrist and a pharmacologist. One could argue that a guideline on the treatment of psychiatric disorders should always include other professional groups or at least have patient representatives. We had lengthy discussions on this and there are obvious reasons why we should have had such representatives. When we opted not to have them in the end, it had to do with what I mentioned above, the feeling of ownership by psychiatrists. When producing guidelines in a field with such controversies, we wanted the message to come across as evidence-based advice form one colleague to another, not as a political compromise between parties that stand far from each other in emotional trenches. It may be viewed as quite paternalistic, but in the end, I think we even serve those most skeptical towards antipsychotic drugs better this way.

You are seven authors, is it really possible that you agree on all your advice?

With seven competent and strong willed psychiatrists, all with long experience in the field, of course we disagreed on many things. We disagreed on what to communicate and even on how to communicate it. But we agreed that it was important to end up with a document that we all could stand behind, and that still was not too much of a compromise. This meant that we each had to "sacrifice" some things. The good thing about science is that we could lean on that and let the evidence rule. Sounds easy, but this was a field with very scarce evidence. Instead, we had a lot of discussion.

Why has not this work been done many years ago?

Good question. I don't know. Maybe because it was difficult. Or maybe because the Directorate of Health has had a "monopoly" on guidelines.

Problems in discontinuation was the topic of a well-visited session at the WPA in Berlin some years ago. Are there any parallel publications from other countries?

Not as far as we have been able to find out.

What do we know about unwanted events or side effects from rapid discontinuation of antipsychotic drugs?

To answer this question thoroughly I would need to repeat a lot of the content of the guide. Instead I urge people to read the report. It is not very lengthy (link in the end of article). In brief, I would say that this is an area with very little empirical evidence. The little evidence we have suggests to "start low and go slow", in this context meaning: take away no more than 25 % of the dose each time and use at least two months on every step, at least if you have been using antipsychotics for some time. Lastly, I would emphasize that you should time monitor the situation on every step.

Has there been much pressure from patients' groups?

No, not specifically concerning this work. There are always some quite distinct voices from patients groups speaking against the use of antipsychotics, but they are there continuously.

Have the Norwegian medical authorities been interested in this topic? For instance, in initiating research which is so sorely lacking?

Very little, if any, research in Norway is initiated by the authorities. Almost all research in "bottom up", initiated by researchers and people working in the field. Having said this, our report includes specific research questions that we believe need to be addressed. Also, we have created a screening instrument for monitoring reactions to antipsychotic tapering. We hope that this will be viewed as an opportunity for those working with tapering. Remember, tapering is a very common thing. After an acute episode of psychosis, many need to taper down their antipsychotics to an adequate maintenance dose. In the drug free wards, initiated by the Norwegian government some years ago, this instrument could be of great use. We hope some will use it and improve it, and research its use, as this is an instrument based on the best evidence now, but this evidence is poor and need to be expanded on.

The most severely ill patients is a priority of the Norwegian Psychiatric Association, so it is understandable that antipsychotic medication come first, but antidepressants are more widely used, so when will there be a follow-up on those drugs?

Our group has no plans concerning this. And I am not sure the need is as great. There are challenges also concerning antidepressant tapering, but most psychiatrists know that this can be solved by slow tapering. The problem of relapse, rebound and a confusion between tapering symptoms and relapse are less for antidepressants.

Have you yourself gained any new insights for use in your practice during the work with this guide?

Working with out-patients, I have shared the fare of many psychiatrists in reducing antipsychotic treatment. Can I reduce the dose and not risk relapse? Even if the main message of the report is to be careful, I will think the meta-message is that tapering is possible and necessary. Of course, we have to taper after acute episodes to find the optimal dose for maintenance. This dose could be moderate, small or even zero. Reiterating this knowledge was for me a good reminder.

Maybe a worse insight is that when you make an effort to put forward the best possible work from colleagues to colleagues to give the best grounds for our work, most of the feedback you get is from colleagues who think you have done a poor job. This may of course be in its place: this work may have many flaws. And we do not mind criticism. But we hope that Norwegian psychiatrists will move from being passive antagonist to more active protagonists. The latter is so much more rewarding and may help our profession forward! ■

Link: https://www.legeforeningen.no/contentassets/ed8d9189acce404b88f405184b7e26ab/kliniske-rad-for nedtrapping-av-psykotrope-legemidler-r1-utentc-1-2.pdf

Specialist Training Program Reform in Finland

Interview with Professor Olli Kampman

Hanna Tytärniemi

Olli Kampman
Professor of Psychiatry. Tampere University, Faculty of Medicine and Medical Technology and Tampere University Hospital District, Department of Psychiatry. Tampere, Finland.

Photo: Jukka Lehtiniemi, Tampere University

Specialist training programs vary remarkably between countries. In some countries there is a final exam for trainees while in other countries there are other ways to demonstrate acquired knowledge in the speciality. There may be differences even among the same country between hospital districts or universities. This interview focuses on the changes in the selection process of trainees in Finland.

Specialist training program in Finland has gone through renovations since the beginning of 2019. There are changes now in the application and selection process as well as the structure of training. What were the main reasons for this reform?

Before the current system, every legalized physician was allowed to get into any speciality training program by just filling a form at the university. In the old system there were excessive numbers of consultants within some specialities and a marked lack of them in some others. Also, there were corresponding inequalities between different areas of the country.

How would you describe the main changes in the current system?

Now there is an applying system twice a year, and every faculty is allowed to take in only a regulated number of residents for training within each speciality. These numbers are based on current statistics and calculated future needs of consultants speciality and area wise. New applicants are interviewed and they will have to pass a six months evaluation period before they can get the final acceptance for specialist training. Also, in the current system the progression in training is determined according to learning based principle compared to earlier time based system.

What are the main principles for choosing applicants for specialist training?

There is a structured interview that has eight questions common for all specialities and two speciality specific questions. In addition to the interview the applicants are ranked according to their working experience within speciality and in the primary health care, and their scientific work.

It is a different question to be accepted in the specialist training program and to be employed by a hospital or clinic. Does it make a difference to getting a job if a candidate is being accepted or not in the training program?

At least currently not directly. It is though likely that after this system has been in use for several years, those accepted for training will get the priority.

Is it possible for a doctor to be assessed "not suitable" for a certain specialist training program? Or the opposite, if there is lack of competition in certain specialist training programs, is there a risk that poorly suitable persons would be accepted in these training programs?

In principle this is possible. However, the evaluation period targets at avoiding situations like this. This evaluation is not dependent on the number of applicants, so it should not make any difference. It is to be noted that cases like these are practically rare, as young doctors are mostly well aware of their own strengths and weaknesses.

Currently there is a literal final exam for each specialist training program in Finland. Will there be any changes in this?

It is possible that in some specialities the traditional examination will be substituted with a more practical series of skill evaluations, for example I could imagine that operative specialities could get benefit from this kind of system.

Let's compare two imaginary applicants for specialist training in psychiatry. How would you evaluate their chances?

Person A is licenciate in medicine (2010) and a specialist in occupational health care (2018). His/her work experience covers nine years in occupational health care and six months in psychiatry. S/he never did any scientific research except for a short compulsory topic in anatomics during basic medical training.

Person B is licenciate in medicine (2017) and Doctor of Medical Science (2019, Thesis in psychiatry). His/her work experience covers one year in psychiatry and nine months as a general practitioner.

Both A and B would currently have good chance to be accepted for the evaluation period, anticipating that the interview was successful.

What are your first impressions of this system reform?

I believe, and at least now at the early stage it seems that this reform is welcome both from the viewpoint of trainees and training organizing units. ■

A Week of Joy (and Misery) in a Psychiatrist's Life

- Consultant Psychiatry above the Arctic Circle

Hanna Tytärniemi

Time and location: February 2020. North Western Lapland, Finland, about 200km North from the Arctic Circle. Working in small communes as a visiting consultant psychiatrist in primary health care. Our Lapland holiday home has become my working home.

Monday: I'm driving about 100km to my workplace in Enontekiö. There was a snow blizzard during the night, and this means terrible driving weather. The road is bumpy with different kinds of layers of snow and ice. Fresh snow is whirling in the air each time another car passes by. My comfort and great pleasure at long driving distances are audio books, especially Nordic Noir!

Today's work goes smoothly, I meet a few patients together with psychiatric nurses. There is only one other doctor (GP) in the health center today. We discuss an acute psychiatric hospital referral case of his. Together we plan differential diagnostic lab tests for a patient of mine who has a lot of somatic symptoms related to depression. I refer one patient to occupational rehabilitation, the closest clinic and central hospital being 300km away in Rovaniemi. Can you imagine that we have patients who travel this distance even weekly for some of their treatments! For example, attending a peer support group for chronic pain patients takes about 12 hours with all traveling.

In the evening I relax in our traditional wood heated sauna. A sauna is a natural way to relax for most Finns, I do it several times each week. This time I also take a quick roll in the fresh powder snow - trying to battle an emerging slight flu.

Tuesday: Driving about 120km to work in Karesuvanto. A lot of trucks operate this narrow road to Northern Norway and truck accidents are common. A truck has slidden off the road and stuck in deep snow. I return to check if the driver is ok. While making the U-turn I almost get my own car stuck on snow on the side of the road!

This remote health care unit is mostly operating with two nurses, GP visiting twice a month. I visit every few months. One patient of mine arrives to the reception by snow scooter, "much more practical", she says. Recently our psychiatric nurses organized a psychoeducative peer support group for depressed patients. It's nice to hear good feedback from patients and nurses.

On my way back home, I cross the border to Sweden to visit a local butcher's. Buying some delicious reindeer and elk meat and Arctic char to my freezer!

Wednesday: It's my day off. It actually means two video conference meetings related to my association work. I am also planning part-time entrepreneurship and there are a lot of applications to fill for Finnish authorities.

During the day I have time to take my energetic dog out in the snowy forest. There are no tracks of any kind here and I use my extra wide skis to progress in the deep snow. I love to watch how my dog enjoys running free and sniffing wild animal tracks of rabbits, foxes and grouse. The forest is a true winter wonderland with heavy snow loaded in the trees and absolute peace and quiet. A gym workout in the evening with my spouse. Our closest gym is 30km away so it's much more practical to organize workout at home.

Thursday: I drive about 150km to work in Pello. This is my longest commute and it takes 3,5 hours per day, although only once per month as we are now using telepsychiatry as well.

This photo was taken on Christmas day a couple years ago. This is what polar night looks like in the middle of the day. Photo Teemu Hostikka

I meet a few patients and we discuss consultations with psychiatric nurses. Lack of resources for psychiatric care is always present in all of these communes. Here they are still lacking a psychologist for the one single vacancy they have. There are no actual chances for face to face psychotherapy in remote areas. It is rewarding that I have helped several of my patients gaining first access to psychotherapy by video.

Friday: I commute about 50km to Kittilä, a short distance by Lapland's scale. Having your own car is compulsory as group transportation is very limited here and mostly suitable for skiing centers for tourists.

Meeting patients and consulting GPs and psychiatric nurses. I have to use four different medical software systems in each commune. Here, I can use my favorite software and I also have a chance for dictation. Making work much more effortless!

Saturday: Normally we like to spend weekends snowboarding in the fells of the national park. Today it's too foggy and windy to go freeriding in the open fells. It's a perfect weather for a long skiing trip to a wilderness hut. We light a fire in the fireplace and enjoy hot sausage and warm drinks. Like most other Finns we spend the Saturday evening by having a sauna and relaxing by the TV.

Sunday: We have a record amount of snow this year in Lapland. Official measurements say there is now 120cm snow here. Our old storage building has 70cm packed snow on the roof and the heavy load must be relieved. I succeed to battle my fear of heights by climbing to the roof and shoveling the snow away. After the heavy work is finished it's easy to jump off to the huge mass of soft snow. No need for gym exercise for me anymore! I take my dog out running and pulling me in a traditional kick sledge. Sauna is a natural way to end such a day. ■

Hanna Tytärniemi
MD, consultant psychiatrist in Lapland Hospital District, Finland. Hanna Tytärniemi is also active in several psychiatric associations and is one of the editors for The Nordic Psychiatrist. In her freetime she enjoys the nature, freeride snowboarding and mountainbiking.

A Week of Misery (and Joy) in a Psychiatrist's Life

- Consultant Psychiatry above the Arctic Circle

- Part 2.0: COVID-19 is Arriving to Finland

Hanna Tytärniemi

Time and location: End of March 2020. North Western Lapland, Finland.

One week ago, Finnish President and the Government have declared a state of emergency in Finland due to the Coronavirus situation. Public meetings have been restricted radically to groups of less than ten. The border traffic is basically closed. Schools have closed last week and students studying remote. Children's day care is limited to critical sector professionals' children.

It was only two weeks ago when we had our annual meeting of Finnish Psychiatric Association in Helsinki. As group meetings were restricted, we canceled the second day of our symposium. Now psychotherapy and psychiatric receptions are mostly held by video meetings or phone calls, as was instructed by authorities last week. Many unurgent activities are postponed or canceled. Rehabilitation services mostly postponed, perhaps for months.

The actual epidemic has not yet reached Lapland. Most confirmed cases have been diagnosed around capital Helsinki in Uusimaa region. We still had masses of tourists in Lapland only last week, so we are expecting to see positive cases soon. Our skiing centers closed down just few days ago and tourists are now finally returning home. In these small remote communes, the health care system has no capacity for tourists and even a third of inhabitants are elderly risk group for COVID-19. Social distancing is not the biggest challenge here, because population density is around one inhabitant per square kilometer and social distancing is the usual lifestyle here. The Uusimaa capital region is now restricted from the rest of the country.

Monday: I visit Enontekiö health center. Only a few commuters on the way, I recognize all of them being critical sector professionals. Primary health care is making protective changes at work. We restrict patients from health center, doors locked, only certain cases advised to arrive to reception. I phone call my patients as they don't have access to video conference. Two GPs working today, also they do a lot of work remotely by telephone or computer. We have a short coffee break standing outside, keeping two meter distances from each other. We have only a few doctors and nurses and I don't want to risk any of them. This is my last time to visit Enontekiö for months, I think. I will continue this work remote from Muonio where I have access to the same medical software.

Tuesday: My usual telepsychiatry day for Pello, working from home. We have started telepsychiatry just recently and still learning the process of planning the day with nurses. For instance, there is still the idea that most patients are expecting face-to-face reception although the instructions are now that most cases should be handled remotely. Also, I will have to learn a new way of pacing my work at patient discussions. Having a video meeting radically limits simultaneous use of patient files and this makes working slower. I've noticed a huge change in the number of phone calls, e-mails, messages by SMS/WhatsApp/Messenger etc., as we are all now rescheduling and reorganizing things and face-to-face meetings are suddenly canceled.

I'm using even three laptops, two telephones. Also my spouse works at home and we both need video contacts and occasionally the WIFI is getting slower. For certain activities I'm sharing my cellphone's internet for my computer. We also need to discuss the use of different rooms at home. Our holiday home does not have two ideal working rooms for work privacy. I can't believe how slow today's work was, although I had only a couple patients! I'm exhausted in the evening.

Wednesday: I commute 30km to Muonio. I don't have remote access to the medical software from home so I will do remote patient work from my usual work room. Today the psychiatric nurse is working from home. We have two successful video receptions with patients connecting from home. Some patients I contact by the phone. Some patients report they enjoy being alone at home anyway, so they don't mind the restrictions. Obviously, we discuss the Coronavirus epidemic with each patient somehow. Again, I notice that we will have to discuss our processes and communication to avoid unnecessary phone calls and messaging between professionals. It seems like there is an overload of beeps from all kinds of messaging devices now.

Aurora borealis are often visible in the winter nights. Photo Frans Vosmeer

Commuting back home I notice some tourists at a sightseeing stop. Frustration arises. I hope everyone would stay at home now.

In the evening I make a short skiing trip in a private simple ski track. Public ski track maintenance has been stopped in order to prevent the attraction of tourists in Lapland. Spotting a couple of white grouses in the forest is somehow comforting.

Thursday: It's my day off yet I spend half of the day working. I'm attending video meetings that mostly concern work changes related to epidemic. As I am working with four different clinical organizations, they all have different changes now and it means a huge amount of communication for me now. There are also tasks related to my association work. For instance, I am preparing the Nordic Psychiatric Associations' (NPA) annual meeting by video conference. A lot of changes, a lot of studying. I'm wondering about the differences in Nordic and Baltic countries. Sweden has made less communal restrictions and I wonder if the psychiatric professionals have continued working in the usual way. A few weeks ago, I could not have imagined the amount of extra work it requires to suddenly change the arrangements of clinical work in such a short time.

In sunny afternoon I have time for a skiing trip. In the evening I realize that I have been in contact with about 10 GPs, almost 10 psychiatrists and a few more nurses today. Most contacts were very positive. My social contacts are actually increasing during this social isolation!

Winter camouflage is still necessary in the end of March. Photo Frans Vosmeer

Friday: Commuting 80km to Kolari. It may be my last day working face-to-face with patients for a long time now. It's quite a chaos as most others are now working remote and we have not had time to prepare for changes in work processes. It's a long day and driving home in the evening feels heavy. The road is awful now when weather is warming up. The road is partially covered by a thick layer of ice and partially the asphalt is revealed, and frost heave is causing a lot of big bumps on the road.

In the evening there is nothing better than having a sauna, a glass of wine and relaxing on the sofa.

Saturday: It's a crazy snow blizzard out there, snow blowing sideways horizontally, and our windows are covered with fresh snow for a while. Snow blizzards are not very common at this time of spring. We still have about a meter of snow in the forests. I plan to spend a relaxing weekend with my spouse and my dog. Perhaps a careful trip in the fells after the blizzard or playing some music together. My friend is organizing a virtual party in the evening via a chat system.

Sunday: The nature gives me strength and comfort. Spring is coming with or without Corona! I'm breathing the cleanest air in the world here. The stars and aurora borealis are there. The pink evening sky and silhouettes of the fells continue to calm me. The rabbits and grouse are now white but changing their camouflage later. Soon reindeer are moving around more with their offspring. Daylight is lengthening and soon we will have 24/7 midnight sun for couple months. ■

Psychiatry in the Time of the Coronavirus

Jacob Jorem

“Psychiatry of Pandemics” offers important insights into the mental health response to a pandemic outbreak in the time of the coronavirus. The book combines clinical aspects of disaster and psychosomatic psychiatry with infectious disease responses at the various levels of a pandemic. It also includes interesting discussions on contagion theory and emotional epidemiology, and thereby accentuating how the crowd can impact individuals’ behavior or emotions during a pandemic.

Jacob Jorem
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President of the Norwegian psychiatric residents’ association
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Mental health in previous pandemics

“Psychiatry of Pandemics - A Mental Health Response to Infection Outbreak”, edited by Damir Huremovic, was published in 2019, before the advent of the current COVID-19 pandemic. The book sets out with a chronological presentation of previous pandemics, which have occurred with irregular intervals throughout human history. The Spanish flu of 1918, as the last catastrophic pandemic, occurred before the emergence of modern psychiatry. Later outbreaks, including HIV, Ebola and Zika, have amply demonstrated the mental health effects which follow the spread of infectious disease. Moreover, these outbreaks have been preludes to a catastrophic pandemic in the twenty-first century (“Disease X” according to the World Health Organization’s terminology), which is currently upon us.

Handling mental health issues in the different stages of a pandemic

The book “Psychiatry of Pandemics” addresses several issues concerning mental health that have come to the fore in the ongoing COVID-19 pandemic. This includes the mental health effects on bereaved family members who may require psychiatric support and care. Both survivors and their loved ones may experience social stigma which can have effects on their mental health. Moreover, previous pandemics have shown that the absence of mental health support systems have amplified the risks of enduring psychological distress at a community level. The book also provides interesting perspectives on the mental health aspects of immunization and vaccination, including immunization hesitancy.

Patients who are placed in isolation and quarantine are vulnerable to neuropsychiatric complications. As an example, there are growing concerns in the Italian Society for Social Psychiatry of an increase in psychopathology, particularly paranoid, obsessive, compulsive and suicidal behavior, following the spread of COVID-19 in Italy, which is among the countries hardest hit by the current pandemic. The book stresses that some diagnostic entities may require special attention during isolation and quarantine, including delirium, anxiety, depression and substance use disorders and cognitive disorders. “Psychiatry of Pandemics” gives useful advice on how psychiatrists can treat these different mental health issues during a pandemic.

Providing psychiatric care to survivors and healthcare workers in the aftermath of a pandemic is crucial but poses several challenges. The book gives valuable perspectives on treating common psychiatric illnesses among both survivors and health care workers, e.g. the psychopharmacology of a post-pandemic depression. Furthermore, the book stresses the importance of preparedness in meeting the challenges of a pandemic, where knowledge of assessment, differential diagnosis, medical complications and treatment is essential for the psychiatric care provider.

Contagion theory and emotional epidemiology in pandemics

Contagion theory can be subdivided into emotional and behavioral contagions. While emotional contagion is the spread of emotions through populations, behavioral contagion is the propensity for certain behaviors exhibited by one person to be copied by others.

There are several factors that affect the rate and extent of emotional and behavioral contagion, including the density and number of the affected community, the personality of the individual, openness to receive and transmit emotions and behavior, and the degree of interdependence of the community. Such mass behavior is both uncontrollable and unconscious by the individual. It is interesting to reflect on the extent to which these factors affecting mass behavior ring true in the current COVID-19 situation.

The discussion on contagion theory lends itself to the concept of “emotional epidemiology”, which is concerned with the public panic in the wake of the rapid spread of disease in a population. Similar to the epidemiology in the spread of a physical disease, “the public, psychological aspects of the outbreak have kernels of misinformation, feed on uncertainty, grow in doubt as they incubate in the limbic system, and then, through vectors of media and communication, explode in form of individual or mass panic, threatening to overpower the coping resources of an individual or an entire community” (p. 37-8).

“Emotional epidemiology” thus stresses the importance of addressing an emotional pandemic accompanying the outbreak of a physical one. To illustrate, the Italian Psychiatric Association has reiterated that “Remember, feelings are contagious too!” during the current coronavirus pandemic. Knowledge of these emotional effects gives mental health professionals an important role as liaisons between epidemiologists, public health officials and the general public.

The need for more research on psychiatry in pandemics

In sum, “Psychiatry in Pandemics” provides useful perspectives on handling mental health issues in the different stages of a pandemic. When considering the limited literature on the topic and the ongoing COVID-19 pandemic, this book could hardly have been more timely. Hopefully, the ongoing pandemic can give impetus to further research on the topic and accentuate the importance of upholding a mental health perspective on pandemics both in the short and long term. ■

Professor Dr. Emil Wilhelm Magnus Georg Kraepelin and the Imperial University of Dorpat

Mari Järvelaid

Mari Järvelaid
works as a psychiatrist at the Centre of Psychiatry and Psychotherapy Sensus in Tallinn. Her alma mater is University of Tartu, where she defended her PhD in 2004. In addition to daily work as psychiatrist, she has worked as an EU health expert in Mongolia and Tyumen Region, and in 2018, she was a visiting professor at Zanzigu University, Kazakhstan. Mari Jarvelaid has published more than 100 publications - scientific and for wider public.

Emil Wilhelm Magnus Georg Kraepelin was 30 years old when he becomes a professor and head a clinic of neurological and mental illnesses of the Imperial University of Dorpat. In his memories he describes it as follows: "In April 1886, I received a letter from Dorpat from my old teacher, H. Emminghaus. // author's note: At that time, H. Emminghaus was a professor of neurological and mental disorders in the Imperial Dorpat University. Emminghaus moved to Freiburg, Germany, as a professor, leaving his professorship vacant. // He had become professor in Dorpat and had now been appointed to Freiburg. As I had already told my wife that if I was ever to be appointed at all, then I would be appointed to the University of Dorpat; my prediction came true." (Kraepelin 1987, p 34).

Kraepelin accepts the invitation from H. Emminghaus, his letters of recommendation were from W. Wundt, H. Emminghaus and F. Jolly. Kraepelin was chosen from three candidates and was considered as the best candidate. So, Emil Wilhelm Magnus Georg Kraepelin was elected Professor and Chair of the Department of Nervous and Mental Disease at the Imperial Dorpat University on 30 May 1886 (Kraepelin 1987, Personal ..., Bibliografitseskii ... 1903).

Kraepelin traveled from Germany by ship to Tallinn (then Reval/Revel) and then by train to Tartu (then Dorpat). He describes his arrival to Dorpat: "The incredibly slow, sheer endless journey to Dorpat with long pauses at every small station gave us a good impression of the Russian railways. In Dorpat, Professor Dragendorff // author's note: the dean of the Faculty of Medicine, Professor Georg Dragendorff (1836-1898) // was waiting for us at the station and packed us into a neat vehicle belonging to the psychiatric clinic, drawn by two brown horses. … The clinic, made of wood, was situated on the edge of the city with a pretty view of cathedral towering up above the trees and the river. … Our first impressions were pleasant."(Kraepelin 1987, pp 36-37)

Emil Kraepelin took the oath of professorship on July 23, 1886, taking up his duties as an ordinary professor at the Imperial Dorpat University. The inauguration lecture "Die Richtungen der Psychiatrischen Forschung" ("Trends in Psychiatric Research" - Estonian) took place on Saturday, September 6 at 12 noon.

Kraepelin as chief physician at the Nerve and Mental Hospital

Kraepelin was waiting for a new hospital building in Tartu, but in his memoirs he describes the fright he had when he saw that the building was made entirely of wood and gas lamps were used, so the environment was extremely flammable. His first job was to arrange the installation of fire alarms and the use of extinguishing equipment in hospital buildings: "I had electric bell wires installed in all the wards as well as a switch, which set the whole system going by one single movement and alarmed the fire-brigade in the city by a trunk-line." He decided to do the whole installment himself with the help of his assistants Dehio and Michelson, so they spent weeks laying the wires and making the connections. His relief was that the hospital never burned down, although there were some minor incidents where the unleashed fire was quickly extinguished with little damage. (Kraepelin 1987) //author`s note: Let us remember that at that time, gas was used to produce light in the city of Tartu; It was only during the First World War, when the supply of gas failed, that the use of electricity became more widespread in the city of Tartu. There were exceptions, so the university's main building used electricity as early as the late 19th century, with a small generator in the physics cabinet. (Lea Leppik, personal interview, 2016) // Further improvements were made by coating the wide corridors of the clinic with linoleum and little washhouse with drying room was built. Kraepelin has written in his memories: "Once, I left a very agitated patient in the bath for three days, because it was too great a risk to put her into the isolation room and she could not be kept in bed. Based on the good success of this method, the bats were used more frequently and in Heidelberg, a systematical procedure was developed." Kraepelin 1987, p 40.

A total of 767 patients have been treated in Kraepelin inpatient care for five years, working in Tartu, 88-90% of whom were receiving treatment for the first time. (Järvelaid 2008) At the time of its predecessor, Emminghaus, the hospital had treated a total of 501 patients. (Bibliografitseskii ...) A review of the work at the psychiatric clinic states that, while in 1885, 99 patients were admitted to the hospital, in 1890,

189 patients, and the budget of the hospital, which in 1885 had been 15,630 rubles, was 32,016 rubles, or doubled. (Bibliografitseskii ... 1903) Kraepelin describes in his memoirs that the second fright was when he discovered that the hospital had 11 thousand rubles unpaid bills. At the time of Kraepelin's departure, the hospital was already making 8,000 rubles for profit. (Kraepelin 1987)

Kraepelin and Estonian language

Most of the patients suitable for teaching purposes only understood Estonian. Kraepelin began studying Estonian, emphasizing that it is difficult, if not impossible, for a psychiatrist to work without a patient understanding the language. Kraepelin has judged his ability to learn languages well by learning to read in Italian, Spanish, Danish, Dutch and a little Russian and Estonian, working with a dictionary. (Engstrom et al 2002) In his memoirs, he has admitted that he gave up studying Russian and Estonian, when he realized that the success achieved was not in proportion to the time and effort necessary. Kraepelin 1987, p 40. //author`s note: It is known that since 1802 the languages of the university's administration and teaching were Latin and German, but by the end of the 19th century the requirement for the university to switch to Russian and to teach in Russian was introduced. Vladimir Grabar has described this period in his memoirs as the introduction of Russian as a language of instruction instead of German and the application of the General University Rules of Imperial Russian Universities of 1884 to Alexander Schmidt, founder and 1885-1890) all traveled back to Germany, where they had come from. The only exception was August Rauber (1841-1917), an anatomy professor who did not give lectures in Russian but in mixed German and Latin; he was called the "last anatomist". (Grabar 1986)//

As for the Estonian language, a striking example of Kraepelin's understanding of the Estonian language is the description in his memoirs that when he visited a mental asylum in Constantinople in 1895, he was shown a male patient speaking an unknown language. Kraepelin recognized the Estonian language (Kraepelin 1987).

Kraepelin Professor of Nerve and Mental Illnesses

When Kraepelin arrived in Tartu, he discovered that his predecessor, Professor Emminghaus, had read his lectures on Sundays, beginning at 12 noon, and he immediately established himself and began lecturing at a time convenient to him within a week. So, he read a course on psychiatry on Tuesdays and Thursdays from 8am to 10pm, and on Nerve Diseases on Mondays and Thursdays from 4pm to 5pm. Various semesters also included a selection of special courses and private discussions and mentoring of experimental psychology at the physiology laboratory at agreed times. On a daily basis, Kraepelin also had a talk time from 11am to 12pm. Kraepelin has written in his memoirs that in the course of the years at Dorpat, besides his clinical training he was able to hold quite a number of independent lectures about criminal psychology, forensic psychiatry, about the conscience and its disorders and experimental psychology, as well he gave a course on hypnotic treatment. There was never a lack of students for these lectures despite the occasional language barrier, students were enthusiastic learners. (Kraepelin 1987).

Kraepelin and experimental psychology

In Tartu, Kraepelin was able to continue the experimental psychological research begun in the Wundt Laboratory, with the necessary equipment being made in the University Physics Laboratory, and Professor Alexander Schmidt providing the premises for conducting experiments in the house of the newly completed Institute of Physiology. Kraepelin continued with previously begun topics, such as alcohol and tea's effects on sensory, intellectual, and motor functions, which he presented at the 10th International Medical Congress in Berlin on August 7, 1890, when he began with new topics. Based on the results of scientific experiments in Tartu, Kraepelin writes a monograph entitled "Influencing Simple Psychic Processes with Some Mistakes" (published in 1892 in Jena). This was the first experimental psychological and psychometric study on the psychotropic effects of pharmacons. The substances Kraepelin studied as psychotropic drugs were paraldehyde, chlorohydrate, morphine, ether and amyl nitrite; he also studied the effects on the central nervous system of substances such as alcohol, paraldehyde, chlorohydrate, morphine and, as a separate group, treated inhaled poisons such as chloroform, ether, amyl nitrite. (Kraepelin 1994)

Kraepelin as a scientific tutor

Under the guidance of Kraepelin, eight theses were defended in Tartu, seven of them in experimental psychology, and for the first time, the effect of psychopharmaconics on the human psyche was investigated using scientific methods. Kraepelin drew his collaborators on experimental psychological research. In 1887, Kraepelin's assistant and student, Heinrich Erhard Friedrich Dehio, defended his doctorate with his psychometric study of the effects of caffeine and tea on the latency of human psychic processes (Dehio 1887). By the way, Dehio left Tartu and was at Kraepelin in Heidelberg in 1894 (Deutsch-Baltisches ... 1998). It was followed in 1889 by Axel Johannes Adalbert Oehrn on the objective evaluation of individual differences in experimental readings (Oehrn 1889), 1889 Michal Ejner's study of time (Ejner1889), 1889 Bills Adalbert Bertels's attempts at distraction (Bertels 1889k), 1890 (Higier 1890) and Maximilian Falk (Falk 1890) studies of spatial perception on the basis of experimental observations and the study of Kraepelin assistant Eduard Robert Friedrich Michelson in 1891 on the possibility of an objective assessment of the depth of sleep (Michelson 1891). Of the doctoral theses supervised by Kraepelin, the only one in clinical psychiatry was Albert Behr's study of catatonia (Behr 1891), which was later described as an opening act for Kraepelin's subsequent groundbreaking work in clinical psychiatry (Saarma, Vahing 1976).

A large part of Kraepelin`s activity in Dorpat was involved in scientific work. In 1887, a second edition of his text-book was published, followed by a third edition in 1889. He wrote regular reports for the General Journal for Psychiatry and reviewed pertinent papers for the Literary Central Paper. He studied several other mental associations beside the tests of the influence of alcohol and tea on performance, e.g. the influence of physical and mental tasks, sleep, withdrawal of nutrition and the change of activity on the quality of performance. He gained the reputation of a “miracle-doctor” as he was able to use hypnotic treatment learned from Krafft-Ebing and Forel.

In his memories Kraepelin concluded that the general scientific life in Dorpat was stimulating, but a gradual shift in the situation occurred with the approaching and finally strongly established Russianization of the university. After almost five years spent in Dorpat, on the 9th of November, news of his appointment to Heidelberg arrived and Kraepelin returned to Germany to took over the chair of psychiatry at the University of Heidelberg in 1891. ■

Highlights from the Nordic Journal of Psychiatry

Martin Balslev Jørgensen

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

Self-harming patients 15 years later

Self-harm is common among adolescents and is even more frequent among psychiatric populations. This qualitative study interviewed 7 patients 15 years after their in-patient stay. At the time of the interviews, the subjects were in their early thirties and had no ongoing self-harm. In childhood they had experienced a dysfunctional relationship with one or both of their parents, and self-harm was one of several destructive behaviours. Friendships outside the unit were difficult during adolescence. Soon after admission to the psychiatric inpatient unit, relationships with other patients became important and contributed to them wanting to stay at the unit. Meaningful relationships and being part of a social context with healthy expectations were seen as important factors for stopping self-harm at a later stage. The subjects' experiences of their life today ranged from not enjoying it to accepting their current situation. **The authors** conclude that the study indicate the importance of relationships and the social context in contributing to and then ending self-harm.

Hansson K, Malmkvist L, Johansson BA
A 15-year follow-up of former self-harming inpatients in child & adolescent psychiatry - a qualitative study. *Nord J Psychiatry. 2019 Dec 4:1-7. doi: 10.1080/08039488.2019.1697747. [Epub ahead of print]*

Adverse childhood experiences and alexithymia in depression

Adverse childhood experiences (ACEs) have been postulated to negatively affect the development of emotional regulation. This study examines the associations between ACEs, depressive symptoms, and alexithymia in patients with major depressive disorder (MDD). The study sample consisted of 186 psychiatric outpatients with MDD. Alexithymia and its components were assessed using the 20-item Toronto Alexithymia Scale (TAS-20). ACEs were assessed with the Trauma and Distress Scale (TADS). Almost all patients with alexithymia and 80% of non-alexithymic patients reported that they had experienced emotional abuse or neglect. Approximately 60% of MDD patients reported having experienced physical neglect and 30% described physical abuse. Emotional and physical abuse and neglect predicted DDF score. **The authors** conclude that among MDD patients, early experiences of emotional and physical abuse and neglect is associated with difficulties in describing feelings in adulthood.

Honkalampi K, Flink N, Lehto SM, Ruusunen A, Koivumaa-Honkanen H, Valkonen-Korhonen M, Viinamäki H.
Adverse childhood experiences and alexithymia in patients with major depressive disorder. *Nord J Psychiatry. 2020 Jan;74(1):45-50. doi: 10.1080/08039488.2019.1667430. Epub 2019 Dec 6.*

Legislation lead to prolonged hospitalization and increased use of coercive measures

Current Danish legislation imposes that compulsory admitted psychotic patients have the right to refuse antipsychotic medication, which markedly delays pertinent medical treatment. In this retrospective, observational cohort study, data on 34 consecutively admitted patients with schizophrenia, who had been compulsory admitted due to need of treatment, or because they were judged to constitute an acute danger to themselves or others were analyzed. The use of other coercive procedures and hospitalization time was compared. Twenty-three patients accepted to commence antipsychotic treatment immediately, and 11 patients submitted an official complaint, which significantly delayed initiation of antipsychotic treatment. The 11 complaining patients were subjected to 6.8 times more coercive procedures of forced sedative medication compared to the 23 patients without delay. Moreover, the treatment-delay prolonged duration of hospitalization by a factor 2.3. **The authors** conclude that the current legislation intends to preserve patient rights and promote voluntary treatment alliance but may instead lead to prolonged hospitalization and increased use of other coercive measures such as forced sedative medication. They suggest modification of current legislation is considered.

Nielsen MØ, Milting K, Brandt-Christensen AM, Ebdrup BH.
Increased use of coercive procedures and prolonged hospitalization in compulsory admitted psychotic patients, who refuse antipsychotic medication. *Nord J Psychiatry. 2020 Jan 6:1-4. doi: 10.1080/08039488.2019.1709220. [Epub ahead of print]*

Anhedonia and other psychopathology as prognostic factors in First Episode Psychosis

The aim of this study is to examine anhedonia and other psychopathology in First Episode Psychosis (FEP) and to monitor stability along 1-year follow-up period. All participants (137 FEP and 95 nonpsychotic psychiatric controls [i.e. non-FEP]), completed the Comprehensive Assessment of At-Risk Mental States (CAARMS), the Schizotypal Personality Questionnaire - Brief version (SPQ-B), the Brief O-LIFE questionnaire (BOL), and the World Health Organization Quality of Life - Brief version (WHOQOL-BREF). Two different indexes of anhedonia: CAARMS 'Anhedonia' item 4.3 and BOL 'Introvertive Anhedonia' subscale scores were used. It was found that in comparison with non-FEP, FEP patients showed higher baseline anhedonia scores. After 1-year follow-up period, FEP individuals had a significant decrease in severity of anhedonia scores. In the FEP group, anhedonia showed significant, enduring (over time) correlations with impaired role functioning, negative symptoms, comorbid depression, poorer self-perceived quality of life and specific schizotypal personality traits (i.e. interpersonal deficits). **The authors** conclude that anhedonia severity is associated with deterioration in function and a bad quality of life.

Pelizza L, Garlassi S, Azzali S, Paterlini F, Scazza I, Chiri LR1, Poletti M, Pupo S, Raballo A.
Anhedonia in young people with first episode psychosis: a longitudinal study. *Nord J Psychiatry. 2020 Feb 28:1-9. doi: 10.1080/08039488.2020.1733661. [Epub ahead of print]*

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