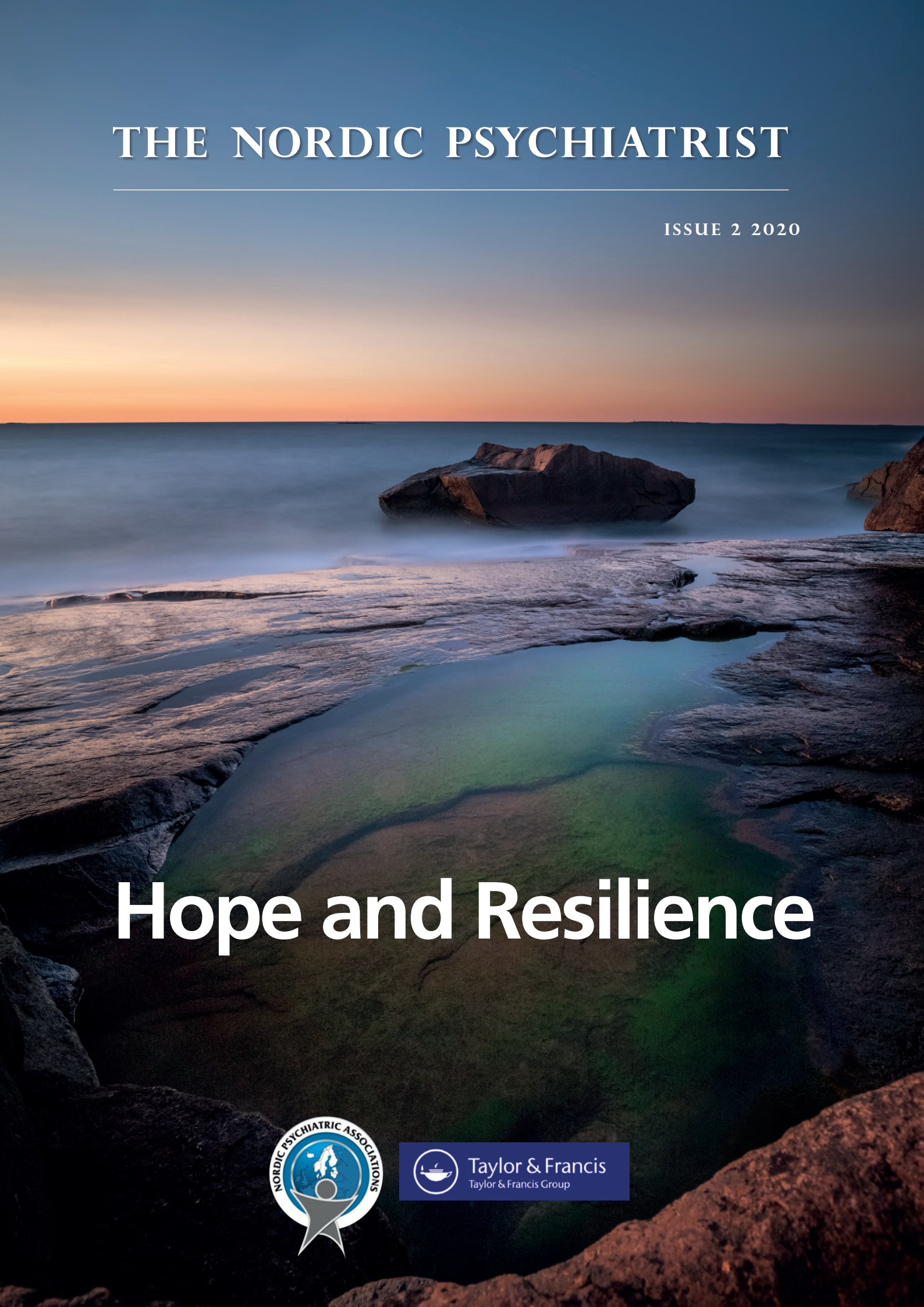
THE NORDIC PSYCHIATRIST

ISSUE 2 2020



Hope and Resilience

NORDIC PSYCHIATRIC ASSOCIATIONS

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Upper row: Óttar Gudmundsson, Hanna Tytärniemi
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Bottom row: Ramunė Mazaliauskienė, Hans-Peter Mofors

Dear colleague,

We are indeed living in different and special times. Never has any of us experienced these new circumstances when our lifestyles are changed, both privately and at work. Nothing is anymore the same.

These new challenges affect us differently. To some, it just means a new way of dealing with everyday life. To others, life becomes more or less a nightmare. Many people suffer from loss of jobs, and others suffer from the new, imposed isolation and loneliness. Some even develop psychiatric symptoms, such as anxiety, insomnia and depression. Unfortunately, many patients will these days wait long before seeking help, resulting in more severe symptoms upon arrival to health care units. We do not yet know how this will change the incidence of suicide in the population.

In other words, life is changed and the future is less predictable than normal. This means a stress to many of us. The ability to deal with stress differs a lot between many of us. This is how resilience is defined. Some will deal with new demanding situations well. To others, it will be detrimental.

As the new negative situation emerges, some will over time lose the feeling of hope, experiencing more and more of despair. This is a mechanism that no doubt contributes to psychiatric illness – and to suicide.

In this issue of The Nordic Psychiatrist, we have chosen to focus on these interesting fields: Hope and Resilience. Fortunately, there are so many colleagues of ours who have much interesting to say about this. Therefore, I can promise you a quite interesting reading.

Hans-Peter Mofors

As always, you will also find many other well written articles and comments.

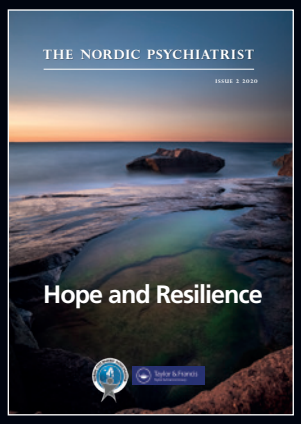
It is, as always, a joy and an honor for me to be part of creating this journal for all our colleagues in the Nordic Region.

Take care of yourself – and your beloved ones!

Hans-Peter Mofors,
Editor

Contents

THE NORDIC PSYCHIATRIST



The Nordic Psychiatrist is published twice a year by Taylor & Francis on behalf of the Joint Committee of the Nordic Psychiatric Associations. The journal is distributed to all members of the national Nordic psychiatry associations.

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PO Box 3255
SE-103 65 Stockholm, Sweden

ISSN 2001-2454

Layout & Design
Åtta.45 Tryckeri Ateljén

Cover photo
Juha Markkula

Printer
Åtta.45 Tryckeri AB,
Järfälla, Sweden

Nordic Congress of Psychiatry 2021 VIRTUAL - Connecting Minds

Interview with Hanna Tytärniemi, chair of Organising Committee

Marianne Kastrup

When the planning of the Nordic Congress of Psychiatry 2021 started the world had not heard about COVID-19

True. We started already in 2017 in the Finnish Psychiatric Association to discuss what image we wanted to convey with the next Nordic congress, choosing the slogan and starting to think of excellent plenary speakers. Personally, I am involved in the organising committee of the congress and professor Tiina Paunio is the chair of the scientific committee.

Our original plans have been built around the typical structures of earlier Nordic Psychiatric Congresses with a Finnish twist. For instance, in our original social program we wanted to provide the participants with a glimpse of what is particularly Finnish, introducing Finnish culture, design, and architecture with a Finnish design tour. We had some more playful and casual social program planned as well, related to some peculiar "World championships" related to Finnish culture. Let's see how we will integrate these plans in our NCP2021 VIRTUAL program.

So the pandemic has changed your plans?

Since the spring of 2020 we have all seen the dramatic changes related to COVID-19. In the organising committee we have had to consider the pros et cons for having a face-to-face congress. There are very many factors to include when taking a final decision, and in November 2020, we had a clear opinion to organize the Congress in virtual surroundings. We are now updating our plans as we speak!

Meeting colleagues and friends in real time and interacting with colleagues from other countries allows you to get to know other cultural aspects and get an opportunity to develop new friendships and maybe plans for future collaboration. I think that this is a part of face-to-face events that most of us cherish. In NCP2021 we are now doing our best to facilitate the same in virtual surroundings. We just have to challenge our beliefs related to the traditional way of doing things.

Hanna Tytärniemi
Psychiatrist. Chair of Organising Committee for NCP2021 Virtual

Has the pandemic had any influence on the interest from the potential participants?

The whole world is right now living in a time of uncertainty, and not knowing for how long this will continue. Thus, many may have been uncertain about their possibility to travel and join the face-to-face congress in Helsinki. We wanted to commit ourselves to the virtual congress so that each potential participant would know in advance that there will not be a cancellation because of restrictions related to the pandemic.

Do you see some advantages with going virtual?

Indeed, there are several advantages. First of all, we can ensure that the congress will be held and not cancelled or postponed related to the pandemic. Also, safety is not an issue if we are still combating COVID-19, so all participants from whichever country can join the event safely. There are obvious ecological positive consequences related to less traveling and less use of materials. Another advantage is a more economical participation fee and absence of travel and accommodation expenses, so many more can afford to participate. It is also easy to combine participation with continuation of your normal life with family, hobbies or other domestic interests. You can even sleep longer in between congress days when there is no need to travel or move between locations. You can even do stretching or yoga exercises or go for a walk in between the sessions. This can definitely support the learning possibilities. As a Finn I can also relate to introverts who may find it easier to attend a virtual event compared to a crowded live conference. So, we may end up by having a different kind of audience compared to many previous congresses.

A virtual congress challenges the concept of a congress. We have to think of new ways to structure the congress, prepare a more condensed version but also think of creative ways to include the audience, organize different "chat rooms" and ask presenters to be innovative in their presentations.

I hear it that you are quite optimistic when it comes to having a virtual event?

Yes, we have rolled up our sleeves, and our goal is to find new ways to attract psychiatrists to join together in a Nordic meeting and experience being part of a Nordic psychiatric community.

So join the congress is my message!! ■

Nordic Congress of Psychiatry 2021 Virtual - Connecting Minds

Introduction to plenary speakers

Hoping that a short introduction to the plenary lectures of the scientific program will tempt you to join the congress and be part of this unique Nordic event. For further information please go to www.ncp2021.fi

Plenary speakers:

Professor Merete Nordentoft, Copenhagen will hold a plenary lecture titled: Improving treatment of people with psychotic illnesses: lessons from randomized clinical trials

She is an expert in suicidal behavior, and a pioneer in early intervention in psychosis. She was PI for many large randomized clinical trials, evaluating the effect of psychosocial intervention, of which the Danish OPUS trial (specialized assertive intervention in first episode psychosis) is the most well-known. She received the award "Global Excellence in Health" in 2012 and 2016; the Richard Wyatt Award in 2016, The Marie and August Krogh Award in 2017, and The Danish Medical Association's Honorific Award in 2018.

Professor emeritus Ian Michael Goodyer, Cambridge will hold a plenary lecture: Adolescent Mental Health: From Brain to Therapeutics.

As a Child and Adolescent Psychiatrist his research uses different approaches to measure the effects of the social environment on cognition, brain structures and mental disorders. The therapeutics research has resulted in a new brief psychosocial intervention (BPI) adopted by NICE UK as a treatment for unipolar Depression in Adolescents. He has received 3 awards and was elected a Fellow of the Academy of Medical Sciences in 1999 and awarded the OBE for Psychiatry Research in the New Year Honours list 2017.

Professor Pim Cuijpers, Amsterdam will give a plenary lecture on: The future of psychotherapy

He is specialised in conducting randomised controlled trials and meta-analyses on prevention and psychological treatments of common mental disorders across the life.

He has more than 900 publications and he is on the Thomson-Reuter Web of Science lists of the 'highly cited researchers' since the first edition of this list in 2014.

Riitta Hari is Professor Emerita, Aalto University, Finland. Her plenary lecture is titled: Brain basis of social interaction.

Her research is on systems-level neuroscience and human brain imaging, and has provided fundamental insights into human sensory, motor, cognitive, and social functions in both healthy and diseased individuals. She has received honoris causa doctorates in science (2003), medicine (2005), and technology (2016), and is Academician of Science in Finland since 2010 and member of the National Academy of Sciences USA since 2004.

Mark Daly is Director of the Institute for Molecular Medicine Finland and with affiliations at the Harvard Medical School, Boston. He will hold a plenary lecture on: Genetic architecture of psychiatric traits and disorders - shared and specific biological mechanisms.

His research focuses on the development and application of statistical methods for the discovery and interpretation of genetic variation responsible for complex human disease. Further he has made major contributions to gene discovery in several disorders and is a co-architect of the FinnGen project, a landmark effort to integrate medical registry data with genomic data in 10% of the Finnish population.

He coordinates the leadership team of the COVID-19 Host Genetics Initiative (HGI) (https://www.covid19hg.org) to bring together the human genetics research community to generate, share, and analyse data to define the genetic determinants of COVID-19 susceptibility, severity, and outcomes. He has 478 peer-reviewed manuscripts and has been listed by Thompson ISI/ Science Watch in 2008 and 2010 as one of the top ten authors ranked by number of high-impact papers.

Dan Chisholm is Programme Manager for Mental Health at the WHO Regional Office for Europe Copenhagen.

He will give a plenary lecture: Public mental health needs and responses in the context of COVID-19: a blueprint for the future?

He works with WHO Member States and other partners to develop and implement national mental health policies and plans, as well as provide guidance, tools and advocacy for the promotion of mental health and the development of prevention, treatment and recovery services across the life-course. His main areas at WHO included development and monitoring of global mental health plans and activities, technical assistance on mental health system strengthening, and analysis of the cost-effectiveness of strategies for reducing the impact of mental disorders.

Resilience in times epidemic

Óttar Gudmundsson

The Corona virus has spread throughout the world at high speed over the last few months. People´s life has totally changed. Existence is no longer foreseeable; instead it is subject to constant change. Travels that had been planned have had to be cancelled; social gatherings and family celebrations have been postponed. The appearance on the street has changed, as a large number of people are walking about with masks covering their nose and mouth as predicted once upon a time in a future literature.

The virus causes both acute fear of being contaminated and fear of long lasting inability to provide for oneself. The impact of the virus on the economy causes unemployment and various and vast difficulties. Psychiatrists see changes in people's mental health that may be traced to the stress that follows this epidemic. The uncertainty is like a heavy weight upon the shoulders of society. Everyone, young and old, can become ill. Making long-term plans is not possible, which in turn people find to be terrifying.

Many have written about the impact of long-term stress and pending risks to people's mental health. The Austrian physician, Dr. Victor Frankl, survived Auschwitz and wrote about his experiences. He addressed, among other things, people's reaction to immediate danger that threatens their entire safety. Terror turns into long-term stress and immeasurable fright.

Usually, the first reaction is denial and shock. Such reaction was common at the beginning of the epidemic. People minimized the impact of such illness, blindly believing in their own health. Many refused to change their ways and believed that the epidemic was not spreading to any major extent. The more denial, the greater the blow when people realized the gravity of these illnesses.

According to Dr. Frankl, the next phase of such reaction to a pending terror and difficulties is apathy. People face the fact that the virus exists, however, gradually learn to live with it. The terror remains, but life continues. People begin to abide by antisepsis rules and believe that this threat is here to stay. This is quite visible in the western part of the world where people accept the decisions of the antisepsis authorities; decisions that limit people's personal freedom. They allow themselves to be confined indoors for weeks on end and consent to all kinds of limitations to their freedom of travel and gathering.

The third phase is characterized by people losing their personality features and melt in with the situation. At this phase symptoms like anger, bitterness and accusations bloom. People lose their personal characteristics and everything evolves around the virus. All inter-

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

ests and conventional topics of discussion disappear when the virus takes over everything. This is quite visible in all news reporting, as the news media cease their reporting about the conflict in Syria or elections; instead they focus on the number of infected people and the mortality rate.

Dr. Frankl defines certain personal distinctive features that are helpful in getting through this kind of difficulties. The most important one is to have some goal or purpose in one's own existence. People who have goals find it easier to tackle various adversities. Those experiencing much lack of purpose in their existence find it more difficult to bear the stress caused by the Corona virus or by other related problems. This is particularly helpful at the third phase of reaction, i.e. at times when the virus appears to be literally taking over all normal existence.

The different reaction by individuals towards the virus illustrates this well. People who have a difficult disposition find it hardest to adjust to the threat caused by the virus. Individuals who suffer depression or compulsion – obsessive behavior, have difficulty tolerating the extensive changes caused by the virus. People with personality disorders with persecution or paranoia find it hard to tolerate such environment of uncertainty and soon withdraw into a world of conspiracy theories. Such individuals put the virus in context with attempts by evil forces for world domination; forces seeking to oppress mankind into obedience.

This latest epidemic clearly shows how the reaction of people to this kind of stimulus is always similar, irrespective of whether this involves serious illness, natural disasters or warfare and persecution. Any kind of stress thus causes changes in man in a foreseeable manner. ■

About the importance of the environment and the individual's resilience

Interview with Marie Åsberg

Hans-Peter Mofors

Few people in Swedish psychiatry are as associated with knowledge about stress and exhaustion as Marie Åsberg. Her psychiatric research spans over decades, and has from an initial neurobiological focus over the years focused more on the individual's symptoms related to their psychosocial context.

Marie Åsberg
Professor Emeritus KI
Researches stress and fatigue,
suicide - KIDS KI at DS.
Educational materials in psychiatry

Like so many senior people these days, Marie has been in quarantine for months, why we meet for an interview over a video link, a communication form many of us in a short time have become accustomed to. To my surprise, it works almost as well as a physical meeting.

Our conversation theme is about both hope and resilience. –"Stress" as a concept means that you are exposed to pressure, but later return to your normal state. Basically, stress is something positive, something that makes us mobilize in pressured situations, for fight or flight. "Resilience" however, can more be described as extensibility and the ability to stretch back, in a humane context the possibility of recovery.

Interestingly, resilience is a concept that for long has been used in the military, and more with a focus on how to increase the soldier's resilience. In our medical profession, we have far too long focused too much on the role of the individual, and his or her vulnerability. Marie draws a parallel with coal workers in the past, who used to bring a canary down into the mine. When the bird stopped singing or died, it was understood that the air was not favorable, and therefore time to get up into the fresh air. Somewhat later the workers went down again (with a new bird?).

There are indeed similarities with how we look at human health. When an individual falls ill from stress at work, employers sometimes gets rid of that person and simply hire another one. There is a danger in focusing on the importance of the individual for falling ill from exhaustion. In fact, several of the personality factors that predispose to this are traits (sense of responsibility, empathy, moral sensitivity for example) that actually are desirable, says Marie.

We return to stress. It has been known for decades that long-term stress is linked to cardiovascular disease, but few know that there is also a link to the development of cancer. Chronic stress changes our biology, but in what way? More research is needed to understand the causes of this. It is quite clear that sleep and security in a group are factors that are protective against stress - and also promote resilience. Marie usually refers to the image of young Swedish soldiers in Afghanistan, who in an extreme situation are able to seek security with each other and in the middle of it all manage to fall asleep.

Some circumstances contribute to transform stress to something negative and dangerous: Such as when we suddenly are overwhelmed by stress, when our coping mechanisms simply are not enough to handle the situation. Some people will then respond with an adjustment disorder or with post-traumatic symptoms. But not all.

Prolonged stress increases the risk of fatigue syndrome. It is precisely the time aspect and the absence time for recovery that is central to the exhaustion process. Experiments on both animals and humans have shown similar structural findings on the hippocampus, prefrontal cortex and amygdala. This is probably due to an impact on centers for stress management. Thus, in a stress context, resilience then means the ability to find factors that protect against fatigue. Some people have the ability to relax in chaotic situations, especially with preserved sleep. These people are almost by definition more resilient.

The positive personality traits such as accuracy, ambition, sensitivity and empathy are highly appreciated. In this way, they are not what we normally would refer to as vulnerability factors, but can still be perceived as such, as people with these traits are more susceptible to be exploited in some working environments. Therefore, it is more the work context itself we must focus on, rather than on the individual's presumed fragility. -How can workplaces be designed to identify and prevent chronic stress? It is not the canary that is basically fragile, it is the air it breathes that is toxic.

Among nursing staff who suffer from fatigue, these personality traits are more prevalent. However, it is the working context itself that has become toxic to them. The typical health care situation consists of a large group of people working intensively towards the same goal. Some of these persons take too much individual responsibility over time.

About 25 percent of people who have been on sick leave for exhaustion relapse later. As in so many other contexts, comorbidity plays a major role. Personality disorder, ADHD and substance abuse are prognostic unfavorable factors.

We also have time to talk a little about the importance of hope. Depression is the condition most commonly associated with hopelessness and can also be suicidal. - One of the doctor's tasks is to be the patient's substitute hope, says Marie, with many years of experience of depression patients. Even in depression, resilience seems to be important. Some people find it easier to endure difficult feelings, to endure in the midst of suffering. Knowing this, new therapeutic methods have been developed, with a focus on treating and relieving the pain of depression. ■

The hope

Óttar Gudmundsson

The most famous football match of the Icelandic history of sports took place in Copenhagen in 1967 between Denmark and Iceland. The Danish team promptly seized total control on the football field, scoring one goal after the other. The Icelandic team leader, however, did not change the structure of his team; instead continued to have his players in offensive mode. The score at mid-game was 6 to 0 and the situation moved from bad to nightmarish. When the position was 9 to 1 goals, Iceland managed to score its second goal. This changed nothing, however, and the game ended with 14 goals versus 2. The biggest scandal in the Icelandic football history was a fact!

Viewing this game it is easy to realize that the Icelandic players soon lost all hope. The defense was neither here nor there and the players hung their heads in defeat. Any will of fighting disappeared from the team! The Danes were encouraged by a screaming audience of thousands and needless to say the Danish players got stronger as the game progressed. The spectators yelled "twenty-to-two", i.e. 20 goals versus 2, to humiliate and break the Icelandic team. The Danish players shone with self-esteem while the Icelandic team lost any confidence they may have had. This game clearly illustrated the importance of hope and optimism in sports and in life. If you lose hope, the battle is lost!

The Greek mythology emphasizes the importance of hope. Prometheus stole the fire from the gods. Zeus took revenge by sending Pandora to Earth to Prometheus' brother. She brought a box with her which she was strictly forbidden to open. Pandora did not abide by the instructions and lifted off the lid, letting out all kinds of misery, epidemics, death, capricious weather, and the most unbelievable plagues that spread throughout the world. She hurriedly replaced the lid, leaving only hope behind. Other problems escaped out of the box, causing difficulties and harm for mankind. The message of this story is that hope is necessary for us all in order to survive all kinds of problems we are faced with. We need to have goals that make our life worth living.

Hope is essential in the struggle against disease. If a patient has lost all faith in his or her treatment and believes that recovery is not around the corner and never will be, the struggle becomes more difficult.

Hope contains a promise of hard times not lasting forever; instead they are but a temporary situation. All religions emphasize the value and importance of hope. Even death is not final! Religion promises life and salvation after death - at a time when everything is to be finished.

Hope is therefore of utmost importance to human life and existence.

The above must be reflected upon in these Covid times. Many people have lost hope and no longer believe that a normal situation with unlimited freedom of travel and gathering will ever return. Covid 19 is one of these epidemics that came out of Pandora 's Box. It is of great importance that we do not lose the hope that remained behind in the box. ■

Resilient organization supports smooth working

Arja Ala-Laurinaho, Anna-Leena Kurki, Hanna Uusitalo

Organizational resilience is a collective capability which is built on organization's culture, structures, processes and tools, rather than an aggregate of resilient individuals with good coping strategies. In resilient organizations employees have shared understanding of the entire work system. They are familiar with collective problem-solving practices and equipped with tools to find ways to succeed in emerging situations. This article is based on studies the authors have conducted in Finnish Institute of Occupational Health.

Working in the midst of surprises

A smooth and predictable workday is a rarity nowadays. Tasks and duties are scattered to a variety of employees across different departments and even organizations, as work is done in different kind of networks and production chains. Information needed at work is stored in databanks, processed with automatic algorithms and shared further via integrated IT systems. This kind of connectedness leaves lots of room for surprises and unexpected occasions in everyday work.

These features of work are examples of effects of digitalization. Though some of the effects cause disturbances and drawbacks in the work, many of them are positive, allowing efficient distribution of work, good situation awareness based on shared information, and collaboration and ideation across geographically distributed units. COVID-19 pandemic has highlighted many advantages of digitalized work processes, allowing working even during times of restrictions and quarantine.

Resilience needed!

In order to get full advantage of digitalization, organizations need to renew their traditional, hierarchical practices and develop new ways of organizing agile working. Organizations need more resilience both in everyday actions as well as in longer term development of their business and operating models. Resilience is about coping with unanticipated situations, learning from experiences, and adapting and renewing activities in accordance with changing circumstances. In resilient organizations structures and practices support individuals and teams to act both proactively and reactively in unexpected situations, and seize collectively the emerging future possibilities.

How to support organizational resilience?

Based on our research, we emphasize the importance of shared understanding of the entire work system for resilient action. Such understanding lays grounds for collective efforts and practices and helps employees consistently respond to changes and challenges in their work.

For example, a practical aspect of digitalization is implementing different kind of IT systems in organizations, which requires changes in the entire socio-technical work system. The implementation phase is often filled with interruptions, disturbances, and unexpected incidents in the use of the new IT system, causing feelings of stress and even despair. According to our research, however, IT implementation process can be managed in a way that helps employees to perceive the entire organizational change, supporting also collective learning and problem solving in the use of the IT system.

Achieving a fluent and smooth use of a new IT system requires that the organization supports learning in three different aspects: the employees need to know the features and functions of the IT system ("what is it about"); know how to use it as a tool in their own work ("how to use it"); and understand the meaning

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of the IT system as part of the emerging new service and production system, or operating model of the organization ("why to use it"). Formal training and e-materials, peer-to-peer and supervisor support, and workshops are examples of practical means for such learning. Noticeable is that this learning should start with creating understanding of the new organizing and operating model: such understanding creates grounds for employees to take active role in the continuous, interdependent development of work tasks, work processes and IT systems as tools, and helps them to connect the single features of IT system into their own renewed work.

In the core of resilient action are, however, understanding the variance of daily work and collective learning and development concerning work processes. Such resilient capability is embedded in the everyday practices, tools and structures, and also fosters resilience in sudden situations as well as in larger reformations as described above.

An example of important practice is organizational problem-solving methods that may hinder or support resilient ways of working. Typically, the daily problems are solved by individual employees. The employee might, for example, ponder the situation, test the solution, or use handbooks, instructions or google. However, building resilient ways of working requires collective problem-solving practices: space and time to discuss the problematic work situations and build the contextual knowledge within the team and collaboration network. This enables wide-ranging and multisectoral solutions that maintain resilient ways of working, which do not rely on the mere personal competences of individuals.

Resilience is putting collective learning into action

Resilience as a collective capability comprises more than just a collection of resilient individuals with good coping strategies; it builds on organization's culture, structures, processes and tools that support collective learning and creation of shared understanding of the changing reality and variance of daily work.

In resilient organizations employees are both encouraged and equipped with tools to find ways to adapt to emerging situations and overcome challenges when work doesn't run as planned or imagined. In this way, the employees are empowered to be resilient actors with coherent actions in the contemporary integrated work processes. ■

Religiosity and faith in God affect hope and resilience in mental illness

Øystein Elgen

At the Norwegian "Psychiatry Week" in March, a well visited session presented clinical experiences and theory on the topic of religiosity, which is often neglected by the secular therapists of today. Psychiatrist Øystein Elgen presents his thoughts on this topic

A young woman who has been treated at a District Psychiatric Center (DPC) for some time was referred to me. She had experienced that her therapist at the DPC was not being able to talk about the patient's faith in God. Like many others I have met as a psychiatrist, she said that she experienced that the therapist thought her faith in God was at best irrelevant to her illness. The patient, on the other hand, experienced faith as a crucial resource for living with the disease. I contacted her therapist, and we agreed to have a joint conversation, where the patient and I talked together about her faith and the disease, with the therapist present. My intention was to normalize and simplify the topic for the therapist, who afterwards expressed that she had learned a lot about the importance of what the patient's faith means as a resource for coping with the mental illness. The focus in a consultation is the person who asks the psychiatrist for help. We need knowledge, theory and methods. But these must never be more important than the person - the patient - experiencing being seen, understood and met.

All human beings have an existential view, that is crucial in their lives. Some are aware of their existential values, others are not. The patient must be allowed to bring this view into the therapy room, even if it is unknown to the therapist. Population surveys show that the majority of the populations in the Nordic countries have a form of religious / spiritual belief, in a personal God or an impersonal force or meaning / destiny.

A great volume of research in recent decades has described that religious / spiritual beliefs have a great influence on people's hope and resilience, on the risk of people becoming mentally and somatically ill, and on how people cope with their suffering and illness. Furthermore, research has found that many patients want the therapist to open up for such topics to be touched upon, but that most therapists believe the patient is not interested in this, that it is irrelevant, or for their own personal reasons will not talk about religious beliefs.

We as therapists have a lot to gain if we take the patient's existential / religious point of view seriously. Already at the beginning of the first consultation I introduce to the patient that they can freely address what is essential in their life, even if they have faith in God that represents difficult challenges or that this is perceived as a resource. Several times I have heard: "Can I do that? I have not experienced that I could in previous treatment, even though it is important to me».

Faith in God can lead to both poorer and better

mental health. There is a big difference in well-being, morbidity and life expectancy depending on whether the belief is positive or negative. By positive faith is meant the belief in a personal good God, who forgives and shows love and care. According to some studies, it gives an average of 10 years longer life expectancy than for those who think that God sees me and punishes me (negative God-belief). The differences in mental health, hope and resilience to illness are found to be similar. There are many reasons why people with positive, personal faith in God come out better regarding resilience to disease; a generally healthier lifestyle, often close relationships, greater security, meaning and hope, and the possibility of a placebo effect, which faith in God is believed to provide. What is found to be effective in placebo is trust, which in reality is the essence of faith in God. Some research results found that when the influence of all such factors is removed, faith alone will still have a positive influence on illness coping. Personal faith also has a greater effect on hope and life mastery than "only" being part of a religious context. A summary of research and a brief description of the more than 18,000 articles on the connection between religion and health (somatic and mental health up to 2012) can be found in the "Handbook of religion and health, 2nd edition". In the years since, almost 1000 articles per year have been added in this field.

Therefore, religious belief and existential views are important topics to understand for the therapist who will help the patient to understand himself and his mental health, and explore his challenges and resources for coping. In the same way as with other topics that the patient addresses, the therapist does not have to have the same basis of life as the patient in order to take the existential issues and the patient seriously. Of course, it is not the doctor's existential point of view or possible "own solutions" that are in focus, but always the patient's.

One patient recounted how her life had lost foundation when her sister died. The parents, in their prolonged grief, were unable to give closeness to the child who was left “behind”. She could no longer trust or believe in God, who had not saved her sister from dying. 25 years later she tells of her pain; that in all the years since her sister’s death she has both been angry with God and longed for the divine. She has struggled alone with clarification about what is true for her, and also what she should think about God. It became clear that this has been a part of maintaining her recurrent depression and anxiety. She is clear that my openness to have faith in God in the treatment has been decisive for her daring to say this, something she had not experienced security for in several previous treatments. It is important to convey that if at any time she asks me to help her to a personal faith in God, I will refer her to another relevant person for such help.

Øystein Elgen is a specialist in psychiatry, senior psychiatrist at Haukeland University Hospital and runs his own specialist practice by appointment to the regional health authority Helse Vest.

Bringing the patient's existential and religious challenges and resources into the therapy room is crucial for many patients to understand what the challenges are, and for the patient being able to find their healthy solutions. Ask wondering questions about these topics, support and say that you would like to listen to this. Research supports that existential foundations and religious belief in God are important for people's hope and resilience - and especially for those who struggle with mental illness. ■

Spiritual care in secular healthcare settings

Ricko Damberg Nissen, Niels Christian Hvidt, Frederik Alkier Gildberg

As humans we are challenged by disease both physically and mentally. Facing the existential aspects of these challenges is at the heart of spiritual care.

Historically, spiritual care, that is taking care of the existential, spiritual, and/or religious aspects (henceforth spiritual) of human life in relation to health issues, was traditionally seen as the job of the nurse (who historically used to be nun or deaconess) and the priest. Despite its historical roots in healthcare, the biomedical revolution somewhat pushed it back so that it was not entirely excluded from healthcare, but certainly not an intrinsic or core part of it either. And what was this talk about the spiritual and the religious anyway? Were we not supposed to have dispersed of such foolish notions, as we were enlightened by rational thought and progress and an empirical basis for our actions in health care? Supposedly so. Yet, as we got busy relegating the spiritual and the religious to the illusory, something else happened.

The spiritual aspects of inmost human life did 'not go gentle into that good night', with strong empirical findings suggesting unmet spiritual needs. Spiritual care has since again gained momentum.

In recent decades international research has shown time and again, that the spiritual is an intrinsic part of how humans understand their personal health and approaching death, and, not the least, how spirituality is an intrinsic (often imperative) part of how we cope with a crisis situation, such as for instance a terminal or psychiatric disease. Research from palliative care and nursing is abundant with literature on how important it is to include spirituality in daily care, and research has shown that inclusion of spirituality in day-to-day interactions not only improves quality of life, it also improves health.

This has resulted in somewhat of a conundrum in the secular northern European countries, namely an understanding, supported by research, that spiritual care is and should be an integral and important part of healthcare on the one hand, and an ambivalence on how to approach this in daily clinical practice on the other hand. We will illustrate this conundrum below, based on findings from a PhD study published in 2019 by the present authors. The study was a qualitative study focused on how psychiatrists in Danish psychiatric practice approach religious patients. It was based on interviews with psychiatrists working in the region of Southern Denmark. 3 quotes from the study will illustrate.

"Religiosity is not really something I look for in a patient" (Informant 13). This quote reflects a common finding in the study and illustrates the mentioned conundrum: religiosity belongs to the

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private sphere and is not actively investigated by the psychiatrist. The quote illustrates an indifference from the psychiatrist, and the potential religiosity or spirituality of the patient is not something that the psychiatrist can use in relation to treatment. For this particular psychiatrist, religion is not only a private area, it is irrelevant.

"If the patient wants to talk about religion that is fine with me, I have no problem with that, but it is not something I bring up, it has to come from the patient" (Informant 10). In this quote, the psychiatrist is open and inviting in relation to religious topics, even though it is still the patient who needs to bring it up. Again, it is the aspect of privacy the psychiatrist is referring to. However, considering that the kind of privacy that hinders the psychiatrist from approaching religion, also applies to the patient, religion might not be an easy topic for the patient to bring up either.

The two quotes illustrate that air of privacy or awkwardness around spirituality that international research has identified as reasons why spiritual care and spiritual coping resources potentially remain dormant and are not brought actively into play.

"It (the patients religiosity) is really good for her (the patient), so I bring it up once in a while when we are moving in that area" (Informant 6). This final quote from the study shows a different and more active approach to the religious patient, in an attempt to activate positive spiritual coping resources (as well as being aware of negative coping resources).

These examples, taken from a study in a psychiatric setting, are emblematic of secular healthcare in general, and illustrate that spirituality is difficult to approach, partly because spirituality is considered a private area, both for the therapist and the patient. However (as illustrated in the last quote), there is a growing recognition that spirituality is a central way of how we humans deal with crisis. This recognition leads to a new focus on spirituality in daily practice, on assessing and addressing spiritual needs in healthcare settings, and on the development of various forms of spiritual care applicable in secular healthcare settings. Spirituality and spiritual care may well find new ways to surface. Now, it is up to the healthcare professionals and researchers in collaboration to develop ways in which the positive aspects of spirituality can be addressed and brought actively into play, ways through which spiritual care may play an integrated and central part of secular healthcare. ■

Hope, community and communities of hope

Knut Tore Sælør

Here's the highway to death and destruction
South capitol is its name
And the school just looks like a shit-hole
Does that look like a nice place?
Here's the old mental institution
Now the homeland security base
And here's god's deliverance center
A deli called M.L.K

And the community of hope
The community of hope
(PJ Harvey, 2016)

We often need to go outside the ranks of doctors to be able to reflect on our own practice, so we asked a registered nurse with a PhD about his research on hope.

I'm quite certain that PJ Harvey had different connotations in mind when writing the above lyrics than the ones I get when listening to her song. Nonetheless, I'll use this excerpt as a starting point in this brief piece on hope, and relate it to the field of substance (ab)use and mental health. Thinking back to my nine years as a registered nurse in various psychiatric wards, I don't think I ever used the word "hope". It had little to do with either nursing or psychiatry. Instead, the word seemed alienated and difficult to grasp. What's more, I believe I was afraid of false or unrealistic hopes, when things were indisputably uncertain. One of the things I discovered when doing a PhD on the phenomenon was that hope is pivotal in times of struggle. It also made me realize that I'm not the only one to find the word challenging to apply in practice. Despite being considered vital, hope received little attention in the mental health and substance use services where I conducted my studies.

The psychiatric hospital I was part of – like the old mental institution in PJ Harvey's song – has closed down. Things do change, but often too slowly. And sometimes old institutions take on new shapes and forms. It's no surprise that people experiencing mental health and/or substance use problems still encounter stigma and exclusion. However, I was baffled by some of the descriptions my study participants gave of the thresholds and barriers in services that were supposed to support them.

One of the things that fascinates me with regard to hope is its apparently paradoxical and contradictory nature. When the outlook is at its most

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gloomy, hope can appear - seemingly out of nowhere. The people I interviewed for my PhD underlined the importance of people they can trust, and who have trust in them, whether they are professionals or not. Price-Robertson, Obradovic and Morgan (2017) have argued: "Experiences such as hope, identity, meaningfulness and empowerment emerge at the intersections between people, their relationships and environments; they are best seen as interactional processes rather than states possessed by any one individual" (p. 112). The psychologist and family therapist Kaethe Weingarten (2000) argues that hope is too important to be left to the individual: "Hope must be the responsibility of the community" (p. 402). Weingarten also coined the term reasonable hope. Not only does reasonable hope rely on relations, it is relational in itself. Not something that can be passed on to others, but rather co-created given the right circumstances. She argues that traditional ways of depicting hope, as opposite ends of a scale, or a dichotomy of hope or hopelessness, do not fit within the chaotic lives people often lead. Reasonable hope can co-exist with despair. Sometimes we have to accept a life situation that we could never have imagined. Aiming for picture perfect might result in nothing being done at all. Despite having to settle for second best, we cannot give up on hope. If we aim for the unattainable, hopelessness is likely to grow. If people are left to choose between hope and hopelessness, chances are they will identify with hopelessness.

Our environment influences hope. Some places leave little hope for change, while others allow it to flourish. Parallel to Harvey's lyrics, it matters what conditions you live in. Inequality and socioeconomic factors influence people's health and can make their outlook bleak. "Shit-hole" schools, lack of suitable housing or not having a decent paycheck are unlikely to make hope flourish. What may be interpreted as psychological symptoms are often the result of poor material conditions. Rather than seeking a definition of hope that is relevant across different settings, talk about hope needs to consider specific contexts. The future is always uncertain, but can be influenced. Reasonable hope should be considered a verb and a practice, not a noun. It is oriented towards what is here and now and what we can do – together – in order to bring people in the direction of a preferred future. Being open to the seemingly unexpected is one way professionals convey hope.

Had I returned to an everyday of nursing, I believe I would have used the word hope - or at least the reasonable version. I would have been less afraid of unrealistic or false hopes. As one of the participants I interviewed said: hopes may change or you may get new ones. I do believe in having high hopes and goals to strive for. But just as vital I believe is raising the socioeconomic standards for those at the bottom of the ladder and decreasing the inequalities we are well aware of, aiming for a hopeful community or community of hope. ■

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Hope and resilience in psychoterapy

Per Anders Øien

An experienced psychotherapist and the chair of the Psychotherapy section of the Norwegian Medical Association makes the link between these two concepts.

Endurance is for the soul
what the hub is for the wheel;
that which binds it all together

(Victor Hugo)

Hope and resilience are two highly important, but, alas, also very abstract, concepts. They are common human factors, but not least vital for patients we meet in our therapy settings. As therapists we probably regard it as essential to be able to 'offer' patients hope, to convey an idea of a possible better future as a result of therapy and their own efforts. I assume that many of us also have felt a kind of hopelessness in our countertransference, facing the nature and volume of problems that patients share with us. A pitfall for every therapist is that we may feel tempted to present a hope even before having fully understood and explored the situation the patient is in the middle of. As Søren Kierkegaard, the Danish philosopher, said;

"That when one is truly to succeed in leading a person to a certain place, one must first and foremost make sure to find him where he is and begin there. This is the secret of all auxiliary art. Anyone who does not know it, he himself is an imagination when he thinks that he can help another. In order to truly be able to help someone else, I must understand more than he - but first and foremost understand what he understands."

In our aspirations to heal or being a successful therapist, we may be prone to overlook this. We should have in mind what Hippocrates underlined; 'never do harm, always console, sometimes soothe, and rarely cure.' It may sound pessimistic and 'passive', but nevertheless more realistic and probably more beneficial to the patient you meet.

I have often felt the heavy burden of the depressing experience that the patient's problems seem so overwhelming that hope appears unachievable. It may lead to a kind of helplessness that it is crucial to be aware of, in order to be able to contain it in stead of acting upon it.

With this challenge in mind, I have often reflected upon the difference between individual therapy and my work as group therapist. It came to my mind an expression from Irvin Yalom's eleven group therapeutic factors; instillation of hope. It indicates a level that is something more and above the concept of 'giving' hope. For some years I ran an analytic group in an acute psychiatric ward. The group met twice a week, and the members were almost

Per Anders Øien (b 1949), MD, psychiatrist, certified group analyst, IGA Oslo, private specialist practice. Head of the national board of psychotherapy, Norwegian Psychiatric Association.

never the same. Many of them were admitted shortly after a suicide attempt, and naturally they were in a state of chaos or despair. As a therapist I was very aware in order to try to turn this despair into a more hopeful position. My experience was that – several times – the fellow patients were able to 'join in' and tell the new ones how they themselves had been in a similar situation only short time ago, and – look at me! – now I am able to discuss my problems with others, I may see the slight light in the end of the tunnel. I often thought that the impact of the peers' statements seemed to be highly more 'efficient' than my efforts as therapist. Probably this is a fundamental both human and therapeutic phenomenon; the experience of not being alone and being understood by another human being. As basic as that.

I have often found myself discussing with my patients the fact that we never know anything about tomorrow or the future in general. We can only assume and it is worthwhile to reflect upon the possibilities that are present in the not knowing stance. The law of chance may as well bring something positive as something negative. Throw of dices.

Here is in my opinion a link to the concept of resilience. Resilience is a rich, viable concept that perhaps mostly is known when working with traumas. I find it very often, regardless of traumas or not, a most useful word to reflect upon. It means the ability to give in when the storm blows, instead of standing firm and erect, which often may lead to a great and abrupt fall. The resilient person has experienced that it may be easier to raise up again, to recover, when the wind has calmed down. The strength in this ability is largely underestimated, and may to a high degree represent the hope that lies in their ability to hold out. This is gold for the soul! ■

Traumatized Refugees: How to support their resilience

Interview with Knud Eschen

Marianne Kastrup

Traumatized refugees have quite different backgrounds, they are offered different kinds of treatment and show different degrees of resilience.

How would you characterize the organization in which you work?

The Department for Trauma- and Torture Survivors (ATT) is part of the psychiatric services, Region Southern Denmark. It is a highly specialized unit, receiving outpatients referred from general practitioners or hospital departments. ATT offers packages with differentiated, multidisciplinary, holistic assessment and treatment to persons diagnosed with PTSD and has a team comprising psychologists, social workers, family therapists, physiotherapists, psychiatrist and a nurse. Our target groups are persons with a refugee- or migrant background with legal residence in Denmark who have been traumatized outside Denmark due to war, political persecution, organized violence, torture, etc. Furthermore, we have a separate unit treating Danish war veterans who have been traumatized in relation to military services outside Denmark.

What comprises the differentiated treatment?

Based upon the complete interdisciplinary assessment the patients are divided into three groups: Those with resp. a high, medium or low level of biological, psychological and social resources (including their ability to mentalize). The group with the highest levels of resources is offered individual trauma-focused psychotherapy and physiotherapy; the medium group is offered interdisciplinary individual or group therapy with a primarily stabilizing focus, and the group with the lowest levels of resources is referred to an outgoing team using a psychoeducational approach. Family therapy is offered to the groups with resp. medium or high levels of resources.

Do you see any relation between the level of mentalizing and the degree of resilience?

Both yes and no – it is my experience that the background of the refugee plays an important role in the resilience. If the refugee was brought up in a family experiencing basic trust and maybe with an upbringing in a peaceful environment, he/she is better equipped to cope with later violations and may also have a better capacity mentalizing. Others may despite a similar upbringing break down when confronted with the atrocities of war and are later unable to manage their life.

On the other hand, you may encounter – however not frequently - refugees with a childhood marked by war, abuse or violence and little trust and yet the refugee manages later on. I recall a case where a refugee had experienced poor attachment in his upbringing but thanks to the treatment and related trust his mentalizing capacity increased gradually.

And what is important in the contacts between refugees and therapists?

As therapists it is essential that we show empathy but also trust and a dignified approach. We shall allow sufficient time to establish mutual confidence and let the refugees know that we are able to contain their stories. We also find it important to witness the stories that the refugees tell. The testimonial method

can be described as a psychosocial approach, which may improve the emotional wellbeing of the refugees.

We work with the feelings of shame and guilt that many refugees suffer from. It may be survivor guilt or guilt for not having interfered in due course. Shame is also prominent often in relation to a history of sexual assaults.

Another technique is that of reminiscence where you encourage the refugee to tell about positive memories, moments of joy and try to slowly build a link to the present situation and in that way help the person to move on in life. It is important to convey that the refugee is responsible and in charge of his/her own life which increases the resilience.

But how do refugees cope with their present life in Denmark?

Unfortunately, many refugees find their existence in Denmark difficult and with continuing challenges regarding daily life, including navigating the Danish social system. It is my firm impression that the vast majority of the refugees have a genuine wish to work and contribute to their new country and that it would improve their resilience to experience being part of the work-force.

What are the outcome criteria for the therapy?

We have to acknowledge that many are severely traumatized but a criterion of success is if the patient is capable of managing his/her daily life satisfactorily or taking care of him/herself in a better way. Another criterion is if the patient has become more active in the family and taken on his/her role as parent.

You collaborate with Save the Children

Yes, we have in Region Southern Denmark a long-lasting collaboration with Save the Children and have developed a concept "Experience club". The clubs are now run by volunteers organizing events in nature for refugee families. We have summer camps where families gather at night around a bonfire which facilitates storytelling, maybe the sharing of difficult experiences or reflections over the past. You also see e.g. a father and his son fishing and sharing a nice experience for the first time in years. Children experience maybe less restrictions and joyful playing and see their parents in new freer surroundings. I believe that these events increase the resilience of the entire families. ■

Knud Eschen is a family therapist and social worker having worked for many years with traumatized refugees. Department for Trauma and Torture Survivors, Region Southern Denmark

Refugee children and youth – risk and resilience

Edith Montgomery

Psychological problems are frequent in children and youth with a refugee background, but the extent of such problems is reduced over time in exile. Traumatic experiences of war and other organized violence is most important for the short-term reaction of the children, while aspects of life in exile are important for the children's ability to recover from early traumatization. The quality of the family life furthermore seems to be important for the mental health of the children in both short and long term.

Families who come to Denmark as refugees have often had a past marked by violence, deprivation, insecurity and anxious waiting. The parents have chosen to flee from areas of war or other forms of organized violence out of a desire and hope to create a better future for themselves and their children in another country. That they have ended up in Denmark is often a coincidence.

Children in traumatized refugee families have often had their own traumatic experiences of, for example, war, imprisonment, persecution and flight. At the same time, they may have lost or been separated from significant caregivers for a longer period of time if, for example, the father has been at war or in prison, or if one or more family members have died. Many children have lived in a refugee camp under difficult circumstances before or during the escape, they have experienced shootings, sought protection against bombing, have witnessed killings and assaults and have had to leave their homes and belongings, often in a hurry. The children react to these experiences, for example in the form of anxiety, they may appear sad and upset, suffer from sleep disorders or be unconcentrated, restless and aggressive. How serious the reactions are depends, among other things, on the parents' condition and how quickly and effectively the family is helped to a safer life in exile.

But do the problems persist? Not necessarily. Follow-up studies have shown that the magnitude of the psychological problems is considerably reduced over time, and that the significance of the traumatic experiences before arrival for the children's long-time reactions is limited. Most of the refugee children and youth integrate well into the Danish society, go to school, get work, learn the language and get Danish friends. Aspects of stressful life circumstances in exile seem to be of utmost

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importance for the children's ability and possibility of recovering from early traumatization.

This does not, however, mean that the traumatic experiences are without significance in the long run, but rather that the traumatic experiences from the home country are thrust into the background as other factors get a more direct influence on the child or youth's mental health. Studies point to following factors as especially important for the long-term psychological reaction of children and youth:

- Aspects of social life in Denmark (including schools, friends and parents' education and behavior)
- Stressful events in Denmark (including discrimination)

The negative factors relate, to a large extent, to the difficulties associated with trying to integrate into Danish society. Networks of friends, supporting institutions and groups, such as schools, can be deciding factors for whether refugees will be able to cope with life in the new society.

Thus, whether or not traumatic experiences have long-term consequences for the child's development and mental health depends to a large extent on what happens to the child after arrival in the country of exile. (Re)establishing a supportive social ecology around the child and his/her family is of prime importance for the healthy adaptation and development. Community interventions should attempt to establish a secure, predictable, coherent and stable life context within which positive experience can enhance healthy development. One aspect of such interventions could be to actively combat discrimination and negative attitudes towards refugees within, for instance, the school setting. Some children will need extra support and professional treatment due to their traumatic experiences, their social life circumstances and family relations. Interventions aimed at enhancing protective factors and reducing risk factors within the various life contexts of the child will with large probability have a positive influence and might prevent psychopathology in the long run. ■

Supporting children's resilience in times of crisis

What we can do as adults to make good memories for children, even in times of crisis.

Piret Visnapuu-Bernadt

A time of crisis needs to be overcome and this requires skills for feeling strong and being able to enjoy life.

Children and young people can react to stress in a number of ways.

A child's reaction depends on his or her age, the state of their health, parental support and previous experiences. In a tense and stressful environment, children may be fearful, withdrawn, scattered, anxious or even irritated and angry. This in turn can cause problems with sleep, headaches, back pain or abdominal pain. Some children will look more closely to their parents, while others will prefer to be alone. Coping with stress can be particularly difficult for children with disabilities and an unusual situation can affect both their behavior and mental stability.

Resilience refers to the process of, capacity for or outcome of, successful adaptation despite challenging or threatening circumstances.

Resilience researchers have identified factors that promote a child's mental health and in turn their resilience:

- A child's easy temperament and good nature. These are dandelion-children, who seem to bloom wherever they grow, like dandelions. Other helpful factors are a child's higher IQ, their good social skills, feelings of empathy with others, a sense of humor, their attractiveness to others, an awareness of strengths and limitations, a sense of identity and agency, their positive values, good self-esteem and self-efficacy as well as good problem-solving skills.

- The early detection of a child's developmental disorders and mental disorders with access to help. A child's resilience is significantly reduced by traumatic life events - experiencing emotional, mental, physical, sexual violence and neglect. The child's mental health is also endangered by the parents' lack of responsibility, addiction disorders or mental disorders. Here, society at many levels has a lot to do, to make the necessary help available and affirming that seeking help does not mean stigmatization, but a change for the better.

- In the family, the child needs warm and supportive caregivers, a good parent-child relationship, parental harmony, a valued social role and a supportive relationship with siblings. It's important that their parents are focused on the family every day, that they find enough time for the children and value the family.

- Where parental conflict exists, a close relationship with at least one parent or other attachment figure helps the child. It's important that the members of the child's family learn from experience.

- More broadly the growth environment needs a supportive extended family, successful school experiences, a valued social role, for example having a job, volunteering, helping a neighbor, a close relationship with an unrelated mentor or extracurricular activities. The key is the ability of an adult outside the family to establish a personal and supportive relationship with the child, if necessary. As they say, it takes a village.

- It's important to cultivate an atmosphere of noticing children and responding to their needs, across all levels of society. Societal risk factors - poverty, injustice and inequality, unemployment, large-scale migration - hurt children very painfully. Many

things contribute to children's resilience in a society: child-friendly family policies, the possibility for parents to be paid to be at home with their baby, flexible working arrangements and a sufficiently good level of childcare facilities. When creating laws, it is important to consider children as a vulnerable group, to follow the rules of child-friendly procedures. In public places, both indoors and outdoors, to take into account the needs of children in accordance with their age, to ensure access and age-appropriate activities.

The main responsibility for the child's well-being rests with his or her parents.

It is up to the parent to create the atmosphere and emotional climate in which the child grows. It is important for the child that the parent is calm and usually in a good mood. The child should not have to worry about the mood of the mother or father who comes to wake them up in the morning. Most of a person's being and behavior has not been consciously acquired. When we communicate, mirror neurons are activated and guide us to behave as we are treated. It is inherent in a person to respond to a smile with a smile.

Being focused on the family, prioritizing being with children, is one of the most important qualities a good parent has. The habit of knowing the child's friends can be an important protective factor in helping a teen to stick to the safe side with their choices. The knowledge that the family is also a home. Your home is a set of sensations, lights and shadows that are hard to describe, but which give a warm, safe feeling.

In a similar unconscious manner, the child acquires the ability to cope with difficulties. When parents are committed to the family and decide to resolve family conflicts, the child experiences that there can be difficult times, disagreements and pain, yet the strength of the parent's relationship determines the outcome. Of course, this does not apply to violent relations; unfortunately, agreements with the perpetrator are often not possible. Studies have shown that experiencing fear automatically raises the levels of the stress hormone cortisol and this persists even after the cause of the fear has long since passed. That is why we are also talking about second and third generation trauma. Getting rid of traumatic experiences requires therapy work, it may not necessarily pass over time. Children benefit greatly from the fact that their parents are not prisoners of their own childhood but have embarked on the difficult but interesting journey of psychotherapy.

Some thoughts to help make good ideas about valuing children and families a reality.

The family needs to have meals together, both morning and evening. The child needs the parents to set their daily routine so that they reach the common dinner table. Eating is not only an activity based on physiological needs, eating together also has a deep psychological meaning. The whole family coming together at the dinner table on a daily basis is a habit that will also be helpful for getting through difficult times.

The feeling of togetherness is not just a party and lofty events. It starts with very mundane things - such as doing housework together. In everyday life at home, the child needs their own tasks and activities. Those which are age-appropriate, relevant, necessary.

Sociopsychological research has shown that a year-old child is very helpful, he helps to open the door, he reaches for a fallen object. If the child can act together with the parent, it stays with them. The child's tasks at home are not to trick them into work education but a natural need for everyone to do something at home. If we do not pass on the attitude that domestic work is not repulsive but perfectly normal daily activity, then there is hope that one day we will not face an alienated adolescent who perceives themselves as an abandoned individual in the middle of a family where no one cares about them.

Both children and parents need play, playfulness. Play is much more than entertainment, filling time left over from work. Play is vital for both children and adults.

Years ago in a South African ghetto, mothers and babies were divided into two groups. In both groups, it was ensured that the infants were getting enough to eat. In one group, mothers were also taught to play with their children, to communicate playfully, but not in the other. At the end of the study, the children whose mothers played with them every day, were found to be better developed in their growth and weight.

The experience of playful, fun communication gives the child a lot. The ability to see life events playfully gives the child mental resilience, the courage to live and a sense of self-efficacy. If you can play, you can find new solutions, you can cope diplomatically in difficult communication situations.

Until recently, a hundred or so years ago, adults also played much more than they do now. In our culture,

we have lost the habit of coming together to communicate, tell stories, play an instrument, dance. However nowadays, playing an online computer game together can be a way for a parent to be with their child, to act together.

The child needs closeness to art, literature and music, it elevates the soul and makes the mind happy, drives away thoughts of worries. Or it helps to survive difficult times, to experience difficult feelings.

A simple and convenient way to collect good memories is to go to nature, such as a park or a forest. In nature, you can conduct immersion and mindfulness sessions, to do sports, as well as feel like a real nature explorer, getting to know plants, birds and insects. Moving around, climbing and jumping is one of the best ways to prevent depression and anxiety.

I believe that children grow up to be resilient, hopeful and courageous in a home, where life is simple yet exciting and where they can love their parents in peace.

Piret Visnapuu-Bernadt
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In the spring of 2020, we prepared recommendations for parents to cope with the crisis in cooperation with the Estonian Association for Infant Mental Health and the Bureau of the Chancellor of Children and Youth Rights.

I am adding a part of this material for parents of young children:

- Be aware of your reactions: control your emotions, learn to stay calm and empathetic;
- Listen to the child and notice their needs and try to meet them: communicate with the child, hold and cuddle them, support their interests and curiosity to learn new things, learn new skills;
- Take into account the child's level of development and set your expectations accordingly;
- Design your family's daily routine and go outdoors with your children;
- Play with the child daily, find 10-15 minutes of time together and let the child choose and control the game, play with the child;
- Borrow from children the curiosity, imagination and joy of discovering and enjoying simple everyday things;
- Read books together, look at pictures, tell stories, discuss together in the evenings what went well during the day and what made you happy;
- Sleep is the basis of mental and physical health: adhere to sleep and bedtime schedules;
- Praise and acknowledge the child and articulate what the child has done well, you can delight each other with a small surprise gift, be it a favorite activity, a delicious bite or an interesting object;
- Take into account the needs of all family members and agree on a living arrangement that includes not only responsibilities but also everyone's favorite activities;
- Limit the child's exposure to the media and rather convey yourself important messages to the child;
- If the child has special needs, keep in touch with the specialists who dealt with the child if possible and continue developmental activities at home via a video bridge;
- If you have any questions or concerns, ask your GP or mental health professional, or consult with your local child protection or social worker. ■

Resilience against mental illness – the role of genes and the environment

Olav B. Smeland, Ole A. Andreassen

"There is ... a quality of resilience, a sturdy refusal to acknowledge defeat, which aids them as effectively in affairs of the heart as in encounters of a sterner and more practical kind."

(P. G. Wodehouse)

A Norwegian Centre of Excellence, NORMENT is exploring the basis and expressions of serious mental illness. We wanted to know their thoughts on the not-so-material subject of resilience. Here is what we got:

The word *resilience* derives from the Latin verb *resilire,* which means to "to recoil" or "to jump back". In physics, resilience is the ability of an elastic material (e.g. rubber) to absorb energy and release it as the material springs back to its original shape. In psychiatry, resilience is mostly applied to the capacity to recover from difficult life events, such as a person's ability to bounce back after a divorce, unemployment, or business setbacks. While inborn inherited factors can both confer susceptibility or protect against development of mental illness, resilience can also be applied to the ability to reduce the impact of genetic risk factors.

State-of-the art research shows that the development of mental disorders is influenced by a combination of genes and environmental factors. In recent years, a large number of risk genes have been discovered for mental disorders, providing new insights into the aetiology of psychopathology. Many of these genes are thought to influence the development of the brain, and in particular the function of neurons, but much research is left to do. One important finding has been that the genetic risk underlying mental disorders is not accounted for by one or a few risk genes, but hundreds of risk genes interacting with each other and the environment. Intriguingly, most of the genetic risk variants are shown to commonly occur in the population. This means that *all* individuals are considered to have a genetic susceptibility to mental illness, on a spectrum from high to low, depending on their unique combination of genetic variants. This not only applies to mental illness, but to common diseases and traits, including blood pressure or breast cancer. These complex disorders are influenced by hundreds or thousands of common genetic variants. Consequently, some individuals are also more likely to be resilient against development of mental illness, given their genetic predisposition. Research has also shown that genetic risk for mental disorders is associated with normal human behavioural traits, like cognitive ability or our personality. Hence, genetic variants influencing risk to mental illness also have an

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Photo: Kirsten Sjøwall

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Photo: Kirsten Sjøwall

impact on basic behavioural and cognitive tendencies affecting our lives, even in healthy individuals. We expect that in the near future, the ongoing global research efforts will lead to more accurate information about how genetic risk influences or protect against development of mental disorders. This genetic knowledge may also help clinical-decision making. For example, patients in an outpatient clinic with vague symptoms but high genetic risk may warrant more extensive follow-up or earlier intervention.

Examining the interactions between genetic risk and environment is a promising approach to help identifying actionable environmental risk factors linked to mental illness. For example, by controlling for genetic risk in population studies, researchers now have the opportunity to study why some individuals with high genetic risk do not develop disease, which can aid the discovery of environmental factors providing resilience. The Nordic countries with their health registries and biobanks, together with public health care system are uniquely suited for these purposes. We are currently involved in studies of resilience factors in the Norwegian Mother, Father and Child Cohort Study (MoBa). This large prospective sample of 114,000 children, who have been followed from birth and extensively characterized in terms of premorbid environmental factors, provides a unique opportunity to identify resilience factors for mental illness.

We are now entering the era of precision medicine, driven by new genetic technologies and big data approaches. Despite the high clinical need, big data approaches have rarely been applied to mental disorders but are mostly applied to somatic diseases like cancer. However, we expect this to change, with a high potential of impact for psychiatry. Among other expected discoveries, we envision that identifying resilience factors may provide the basis for development of novel interventions and prevention opportunities that could help to reduce the large burden of mental illness. ■

REFERENCES available on request

Snorri Sturluson and the detachment theory

Óttar Gudmundsson

The poet and historian, Snorri Sturluson (1179-1241) is the most famous Icelander of all times. His achievements are beyond belief. Through his unique works, he literally saved the Nordic mythology and writings from being lost. His Prose Edda (Snorra Edda) is a major masterpiece. He wrote the story about the Norwegian kings, Heimskringla, and thus saved the stories of the Norwegian royal family from obscurity. It is indeed ironic that a Norwegian king was the one ordering the execution of Snorri at Reykholt back in the year 1241. Usually, ingratitude is the prize of the world.

Snorri was only three years of age when he moved from his parents and was fostered at a major stead of education at the other side of Iceland. Historians have agreed that the stay by Snorri at this stead of education constitutes a major gain for the Icelandic culture. He learned foreign languages and was allowed to read and study contemporary literature. At the age of 20, Snorri returned to his home district, got married and had children. Gradually he became one of the principal chieftains in Iceland.

His time as a fostered child shaped the man, Snorri Sturluson, in many ways. He probably missed his parents and no woman or female caretaker appears to have assumed the role of mother for him. His upbringing was symbolized by a limited and cool attitude, as well as loneliness. His personality bore signs of this his whole life. He was always badly connected to his own community; he lacked trust in others and was paranoid. Snorri had five children but did not bond with them. He did not read his environment well and made various mistakes in his interaction with his relatives and others. He put his trust in people who then subsequently betrayed him. His former son-in-law, who he regarded as his friend, but served the king of Norway and had Snorri killed. Snorri's magnificent story gradually turned into a tragedy because of this lack of bonding and interaction.

Snorri was a world class writer, yet could by no means tackle close relations with others.

Children who are taken from their parents at a young age miss their parents' touch and eye contact. They frequently become unsociable and on guard, and have difficulty in trusting others. These children develop symptoms that remind of autism. They are late

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in developing verbal competence and frequently show signs of developmental deviation. After the collapse of the Soviet Union and their allied states back in 1989, a sizable group of children from this part of the world was adopted by families in Western Europe. Many of these children came from foster homes where they had been raised for a few years without any closeness or bonding. Some of them had reactive attachment disorders and found it difficult to adjust to their new foster families. This disorder is called RAD (reactive attachment disorder). The child is always in an alert mode as if he or she is expecting the worst. Many foster parents find it difficult to interact with these children who had difficulty in expressing their emotions in a normal fashion.

Snorri Sturluson showed several symptoms that remind of these children. Cold upbringing in a foreign environment without actual contact with parents or a familiar face formed his entire life. As the years went by, Snorri became very wealthy but did not like to part with his funds.

He learned during his upbringing that wealth begets popularity and recognition. Yet, this accumulation of wealth also took a wrong turn for him and only caused him misery.

This illustrates how important it is for children to receive physical closeness and bonding by their parents during their first years of existence. Detachment disorder during childhood can affect a child's entire life. ■

A landscape of loneliness – an essay

Peter Strang

Loneliness can be about involuntary loneliness, self-chosen solitude, intrapersonal loneliness or existential isolation. These different forms have far reaching effects on a person's health and are described below in an essay.

Early in my professional life as an oncologist, I became aware of the impact of belonging or connectedness, versus loneliness. In cancer care, it becomes so evident: Cancer is a serious disease and in such situations it is common for loved ones to prioritize and gather around the patient. Children and grandchildren visit more often and adult siblings often resume contact where there has been none. On one level it appears that togetherness grows.

But a serious illness can also increase the feeling of loneliness and isolation, especially if one has a terminal illness and doesn't have a long time to live. In modern society death is an uncomfortable topic, not spoken about and often hidden from sight. Swedes are particularly uncomfortable when death suddenly becomes a possible reality. Many of my patients have told me how people who they thought to be friends, started to behave more like mere acquaintances. They simply stopped being in touch and even looked away if they happened to meet in the street. In short - they felt abandoned and lost the feeling of connectedness to others.

Some of those I have cared for have described this as being behind an invisible shield of glass, which I also tried to portray in the form of a novel in my existential book "I skuggan av sommaren", "In the shade of summer" which is about two relatively young men who happen to share the same room at an oncology ward. Both have the same experience: over the course of a day, they transitioned from belonging to the group of the healthy to being part of the sick. It is as if there was a glass wall between them and the healthy world: They see that world and want to reach out to it but there is an impenetrable glass wall between them and their healthy relatives.

The faces of loneliness

Loneliness has many faces. What first comes to mind is the involuntary, social loneliness, which means that you want social contacts, but have no worthwhile relationships with your relatives and you lack friends. This type of loneliness is also sometimes called interpersonal loneliness.

Involuntary loneliness differs from a self-chosen loneliness, which is better described by the word "solitude". We live today in a relationship stress. Biologically, we humans were made to live in groups of 30 to 150 people, but the last century has changed these conditions. During a weekday in Stockholm, one sees thousands of people in the subway and on the streets. We may think that we have gotten used to it but the brain is constantly at work. That is why we sometimes need privacy, some time alone and preferably out in nature.

In some vulnerable situations, one may also feel alienated from oneself, and that is sometimes called intrapersonal loneliness. I see it in cancer care when a patient exclaims "I don't recognize myself anymore!" Personally, I think that intrapersonal loneliness is and even greater issue in psychiatry, especially for patients suffering from psychosis diagnoses.

Finally, we have existential loneliness, which is the loneliness one can feel in spite of the presence of family, relatives and friends. And that is because in every person's life there are secrets and things we can never fully share with anyone else. Existential loneliness is often encountered in cancer care, but I think it is just as common in psychiatry, even if you may not put it into words. As one of my younger, dying patients put it, "My wife is the great love of my life and my best friend. She wants to understand how I feel but I realize she cannot. If she, who knows me better than anyone else, cannot understand how I feel at heart, then no one can understand it… "That is the real meaning of existential loneliness, even though one often experiences it in much milder forms.

The importance of loneliness for physical health

Since I was involved with issues of existential loneliness in my profession, I wanted to write a popular science book on the subject. But when I started researching the topic, I realized that loneliness has so

much more consequences than one might think. It all resulted in the book *"Att höra till. Om ensamhet och gemenskap"* (Natur & Kultur 2014) where I compiled what we clinicians have long understood but for which there is now evidence: "that body and soul belong together".

It is easy to imagine that loneliness is just a mental discomfort, but there is very strong research that shows that involuntary loneliness has a strong link to cardiovascular disease and the risk of dying prematurely. The evolutionary biological explanation is as follows: Ever since the time of the first humans, threats have been physical: the risk of being killed by lions or by enemies. That risk was especially great if you left the village and the group. The brain has therefore created both protection mechanisms and warning signals, to promote survival. In short, the brain rewards all forms of community by releasing oxytocin (especially during physical interactions), dopamine and endorphins, which make us feel good. This response is similar regardless of whether it is about romantic relationships, singing together in a choir or joint sports activities.

But the warning signals are even more important for survival, and the brain uses both the stress system and the pain system. If our ancestors left the village, stress arose due to the risk of being killed. Our ancestors looked for dangers on the horizon; the body released stress hormones and constricted the blood vessels, because if you were to fight, it was good not to bleed too much. This stress turned into anxiety and discomfort and that feeling drove our ancestors back to the group. From that point of view, the warning system has served us well.

Today, the risk of being killed by lions is very small, but our brains react in the same way they always have: when we are involuntarily alone, stress hormones are released and the blood vessels constrict. As such it is a low level of stress, but if it lasts for a long time, it may lead to cardiovascular disease. Meta-analyses show that loneliness, as a risk factor for cardiovascular disease is equivalent to smoking 15 cigarettes per day.

But the brain also activates the pain center in situations of involuntary loneliness as shown by Naomi Eisenberger's group in well-conducted studies published in Science as early as 2003. Therefore, it is the case that we experience physical pain more strongly if we are alone, while community reduces the pain. This is a "discovery" that all parents of young children have made throughout the ages (as soon as the parent takes up the child and the pain becomes milder…) but now it is also scientifically proven.

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Immunological effects

So in these Covid times, it is interesting to know that it has also been shown that involuntary loneliness results in slower wound healing in animal experiments, e.g. with rats. Rats are social animals: if you isolate a rat from the group, you can study the rate of wound healing compared to wound healing in rats that remain in the group.

But there are even studies on the effects of the flu vaccine. In one study, students were able to self-assess their perceived loneliness / social connection. They then received the usual flu vaccine, after which the degree of antibody formation was measured. Those who assessed themselves most alone had poorer antibody formation! Another consequence is general a pro-inflammatory reaction, e.g. with elevated levels of certain interleukins and CRP.

Mental and cognitive effects

Everyone associates loneliness with feelings of discomfort and fear, that is, the feelings that have historically led us to return to the safety of the "village" and the group. Today there are no or only few physical threats. We live in a new world but the problem is that our genes are old. Therefore, the brain still interprets loneliness as a physical threat to life. For that reason, it can be very difficult to break out of a relationship, even out of a destructive one. For the brain dreads loneliness. It is a pity, because when you do scientific studies, you see that good relationships are protective, while bad relationships are harmful to physical health.

In addition to anxiety, discomfort and fear, loneliness is also associated with the risk of forgetfulness, especially in older people with lower cognitive resources. Studies show that long-term loneliness increases forgetfulness and is also a risk factor for dementia development.

Even on the cognitive level, you see a clear impact, not least in experimental situations that you can create in different ways. One way is the well-known "ball toss game" or "ball tossing game" which in short means that the subject thinks he is playing against two other people over the internet, but soon they just start sending the ball between them, on the screen. The person feels excluded… When you then test, for example, cognitive ability, concentration or perform IQ tests, you see that the person performs worse. Exclusion affects cognition.

Bullying and suicide

Loneliness is the worst thing we can be exposed to, the bully knows it and the person with suicidal thoughts knows it. If you think about it, prison is not in itself the worst punishment, but sitting in solitary confinement is. In prison, you have restrictions but you can hang out, but in the dreaded isolation cell you are cut off from all connectedness and communication. That's what makes it so hard to put up with.

Therefore, one should primarily see bullying from that point of view, whether it is child bullying or adult bullying: one is expelled from the community and the brain reacts with panic. In the same way, I look at suicide. You can, of course, have different starting points when trying to explain suicide, for example based on meaninglessness or from failures. But what often exists as a common factor is loneliness. In a world of involuntary lack of relationships, most things are meaningless and the great pain of a failure is that you have no one to share it with. In the cases I have encountered suicidal thoughts in cancer care or palliative care, it has almost never been about the disease itself but about standing alone with the suffering without having someone to share it with. When I, as a therapist, have captured their inner feelings and tried to share their experience, their suicidal thoughts have diminished. During my 35 years, none of my seriously ill patients have committed suicide.

Social consequences of loneliness and exclusion

Exclusion is actually very closely related to loneliness. We know from studies that if you are being excluded from a group, you react either with sadness or with violent anger. Unfortunately, anger is more common. Therefore, research can link exclusion to school shootings and car fires. Loneliness in the form of exclusion thus also has effects at the societal level.

… and the existential loneliness

I want to end where I started, with the existential loneliness. The experience we can get a little sense of when we look into space on a warm, black late summer night. First it feels beautiful, then we can be surprised by a feeling of loneliness in the middle of all the big things. An "outcast", to use the vocabulary of the existential philosopher Martin Heidegger, a feeling of "thrownness", meaning that we are thrown into a cold and indifferent universe without inherent meaning. We can also experience that feeling in the middle of the party and we just want to go home. And we can definitely feel that way in a serious illness. Here I see great similarities between cancer and mental illness. There are personal aspects of a serious illness that no one else can understand and therefore cannot be shared. Such experiences increase existential loneliness and thus suffering. When you have experienced something terrible, you say *"No human being in the whole world understands how I felt…"* Such an expression puts words to existential loneliness.

For that reason, loneliness is the engine of suffering. As long as we cannot share the terrible and the difficult, the suffering is greatest. The day we can share at least some aspects, however, reduces suffering. This is why the therapeutic relationship itself has an intrinsic value. It is a matter of moving away from professional treatment for a while, because treatment itself is about subject-object: we are acting subjects and we take care of our "care object". It works well for minor problems, then you may want to be taken care of for a while. But in an existential crisis, one needs for a moment a subject-subject relationship, where our horizons of understanding for a moment are merged. If we can create a feeling that "This time it's you who's sick and I'm healthy - but it could have been just the opposite", then the relationship in that meeting can be soothing.

Finally

In this text that I have written in essay form, I have not published references, but all references (89 references) and further reading can be found in my popular science book Strang P: "Att höra till". (To belong to. About loneliness and community.) Natur och Kultur 2014. The existential crisis with a focus on existential loneliness I have portrayed in the novel's form in Strang P: "I skuggan av sommaren" (In the shadow of summer ") (Libris 2017, pocket).

Aspects of loneliness' physical and mental health effects can also be seen in two teaching videos at the Palliative Knowledge Center (PKC) in conversational form (Loneliness' physical health risks, and Loneliness' mental and social aspects)

https://pkc.sll.se/utbildning/videoforelasningar/undervisningsvideor-om-palliativ-vard/ ■

From Impossible to I'm possible!

Cato Zahl Pedersen

Who has more experience on resilience than the man who takes to the South Pole with no arms, and back home sets up a rehabilitation center to support and teach others the skills needed?

Disabled. My new label as a 14 years old boy. From now on should much of my own and others' focus deal with my lack of arms. A small piece for mankind, but a big issue for the concept of normality. I felt like being put in a booth of abnormality, dominated by the negative image, the loss. Reinforced by the rights in our welfare system. A system that demands to find disadvantage through diagnosis. A disadvantage that gives you entrance to given services.

I had climbed too high in a high voltage pole. 17000 volts entered my body. The electricity entered my left shoulder and left through my right underarm. After three months with several surgeries, I leave the hospital with the lack of my left arm and the right underarm. I survived, even some amputeed.

It doesn't ooze energy of disability. My mother's eyes were always filled with tears. She felt so sorry for me. She transfers from the mother who pushed me off the diving board to teach me how to swim, to become a carer who made sure I did not suffer. It infected on the neighborhood, as she spread the fact how difficult it was for me. I must add that I surely loved my mother.

The first phase was of course very challenging and dominated by the negative image, the loss. I as well cried now and then. My dream was to take over the

Cato Zahl Pedersen (62)

Adventurer and Paralympic Champion. Differenabled after an accident in the youth. Achieved 13 gold medals in Paralympics, «Unarmed to the South Pole" (1994), climbed Cho Oyu (8.201 m) in 2005 and Mount Everest (up to 8.650 m) in 2007.

To empower others, he has established a rehabilitation center «CatoSenteret» in 1998, located in Son, south of Oslo.

Working today at Olympiatoppen (Top athlete center) with the responsibility to develop Paralympic participation in short and long terms.

ownership of the farm after my grandfather. My biggest cry was when he visited me at the hospital with this clear message; “We leave the farm to your younger brother, and you start to use your head.” And continued; “Don’t be one of them that we hid when I was young.” He understood that I needed a hard lesson. My schoolwork was poor before the accident. He behaved opposite of my mother, and that was planned.

It is a human right to be asked for expectations and demands. It’s the petrol of life. My grandfather was one of several adults that inspired me to build my new ego identity. I learned the hard way. First to cope with them, later to appreciate their kind of strictness. Their offensive guidance in my struggle to navigate for recognition. Slowly but surely, I woke in my dormant bubble.

The life between the old and new started to accelerate. Through studies and sport, I deconstruct my abilities and redefine my goals. My body holds 37 degrees. That means you are living, and is much more important than the lack of ten fingers. This optimistic sight of life was stimulated by my wife whom I married at age 21. She was kind of the counterpart of my mother, helped me to approach life with creativity, innovative and renewal.

At the end of my Paralympic career I was challenged to do an expedition to the South Pole. My first reaction was; how do I do my toilet out there! Isn’t that typical, how we approach new situations? We meet it with scepticism and our concerns. You walk into the South Pole, as you walk out of the hospital. The long, cold and hard way into Antarctica, I experienced was met with the same way of thinking in the face of the brutal truth that the arms were gone. The only change was the facts. The cold facts of our “Unarmed to the South Pole” was walking on skis 1300 km, temperature -30 to -70 degrees Celsius, 56 days in total, eating 7000 calories of food daily and having a weight loss of 20 kg. The fact of no arms, was more an advantage than a problem. I didn’t freeze my fingers off.

On the expedition I was planning the concept of treatment at the Cato Centre - a rehabilitation centre with the concept – “Your own empowerment in rehabilitation”.

Empowerment for me, is strongly linked to the salutogenetic concept of health. Sitting in my driving seat taking control or power over my life, following my dreams, ambitions and goals. The CatoSenter should be filled with “educational driving instructors”. A skill that my mother also had and used before the accident.

As an adult myself, and as a vision for the CatoSenter, I really want to facilitate others to be their own “happenstance” - something that happens by planned coincidences. Change based on courage, will, flexibility, openness, willingness to try and learn. Doggie.

Dis- is a prefix that can mean either 'double' (of Greek 'two') or 'apart, in pieces, away' (of Latin). I have chosen the Greek version for living. Live for IMPOSSIBLE to be I’M POSSIBLE. ■

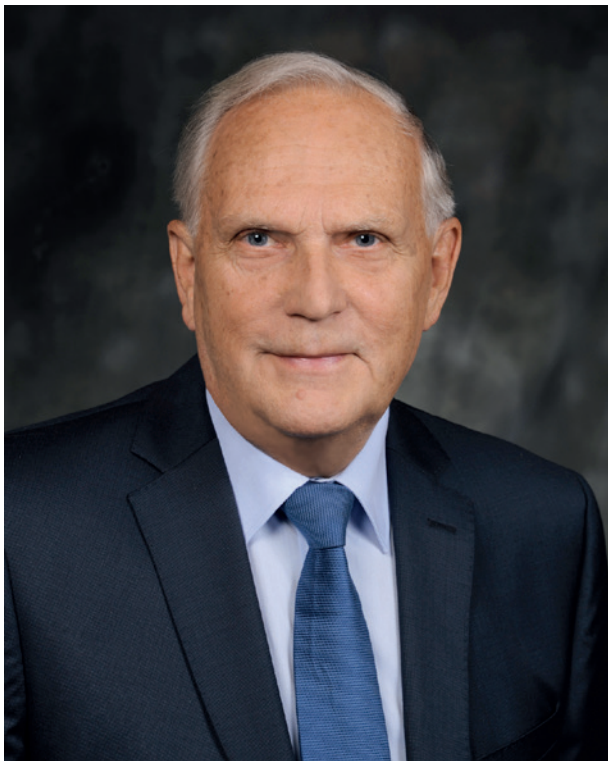
The First National Suicide Prevention Program in Finland

Interview with professor emeritus Jouko Lönnqvist

Hanna Tytärniemi

Finland has been known as a country of high suicide incidence. In fact, suicide numbers were growing until 1990 but since then the incidence has reduced by half. Nowadays Finland has about an average suicide incidence at European level. Professor emeritus Jouko Lönnqvist was conducting the first national suicide prevention program in Finland in the 1980's and 1990's.

Finland was the first country in the world to launch a national suicide prevention program resulting in a decline of suicides. The incidence of suicides had been increasing over the decades and there was a growing concern to stop this direction. There had been developing ideas for prevention in the 1970's but there were difficulties implementing these ideas to action. In the beginning of 1980's the Finnish health care officials decided to start a national suicide preven-



Jouko Lönnqvist
Professor emeritus, Helsinki University and Finnish Institute for Health and Welfare. Group psychoanalyst. Long time clinician in private sector psychiatry. He is still teaching psychiatrists and connected to some research projects in Helsinki University. His main research areas are related to suicidology and epidemiology of depression and schizophrenia in particular. He was awarded The Nordic Public Health Prize in 2011 for his internationally acclaimed research on the causes, spread and prevention of mental illness at population and individual level. Over the years he has worked in several leading positions in associations related to health care research and mental health in Finland, and as an expert in several international organisations such as WHO and European Council. He has over 40 years of experience in consulting business management. Photo: Kuvateemu

tion project. This was an enormous project concerning about 250 mental health professionals in the project core and more than 1000 active participants from different organisations of Finnish society including the health care sector, social care, police, church, the army and governmental bodies. Also, thousands of relatives of suicide victims were involved in the study by interviews.

Officially the project took place between 1986 and 1996 but there were actually several follow-up projects and implementations afterwards. Eventually professor Lönnqvist spent about two decades connected to this project. The first phase included three years of studying in detail all of the 1500 suicides that had occurred during a single year. The psychological autopsy of each suicide case resulted in a conclusion of possible preventing measures for each individual case. Each case and preventing possibilities were discussed in regional working groups, consisting of leading professionals from different areas of society. The purpose of this was to gain wider understanding among several sectors of society - not just mental health care workers - about the reasons of suicides and prevention possibilities. The next phase of the project was to put together a national suicide prevention strategy and a plan for implementation which was published in 1991. The actual implementation took place between 1992 and 1996, followed by an assessment and several other projects in the following years.

One of the main findings of the study was that depression was inadequately diagnosed and treated in Finland and this was a clear risk factor for suicides. "The project gave rise to development of the treatment guidelines for depression. It also underlined the awareness and power of the whole society to work together in prevention of suicides and caring of mental health problems in general. After all, we as psychiatrists meet our patients at a point when a patient has possibly already tried to commit a suicide or is considering it. There are so many other preventive possibilities that can be done before the person is preparing to jump from the balcony. Each suicide or an attempt is some kind of cry for help and we should think about the message behind these decisions as a feedback towards our systems in society and health care."

Today professor Lönnqvist has warm memories of the project. "I like to work for a win-win situation and towards making myself unnecessary - in patient work and different types of working groups. The core working group was very active and the project had several positive consequences. I believe the project enhanced society's attitudes related to mental health problems and nowadays the stigma has been reduced. I hope no person would have such dark shades in their lives which they would not be able to share and discuss with family, a friend or professionals. Also, the way media handles suicides has somewhat improved over the years. Naturally, the reduction in suicide incidence is not only related to the prevention program. For instance, the marked development of cancer treatments has reduced suicides among cancer patients or treatment of depression, psychoses and substance abuse problems has advanced with new medications at the same time. I wish we could improve more the prognosis of patients with earlier suicide attempts and also have more possibilities of preventing the outbreak of mental illnesses such as depression and schizophrenia."

In the end of this interview we share some thoughts related to the prevailing COVID-19 epidemic and what clinicians in psychiatry could do in relation to suicide risks. After all, the epidemic is causing a lot of individual suffering for those infected and their relatives, changes in social relationships, huge economical crisis related to lock-downs and so forth. Professor Lönnqvist underlines again the importance of the society and communities. "If we look back in history, periods of economic crisis or other crisis situations have not resulted in an increase of suicides. The buffering capacity of the society can be surprisingly good but of course this requires the society to take responsibility instead of leaving individuals on their own. Often people in crisis situations can find so many more meaningful things in their lives such as family, friends or a significant purpose to fulfill and the whole society should support this. When it comes to suicide risks there are so many factors in large scale. If we imagine suicide risk as a large network of rivers, we can all try to see ourselves working next to one of the small creeks. What we as psychiatrists should do is very simple - we should treat each patient with best available treatments!" ■

Effect of training general practitioners

Interview with Wolfgang Rutz

Marianne Kastrup

Wolfgang Rutz was the principal investigator of the famous Gotland Project in which psychiatrists trained general practitioners in identifying depression with the aim to treat depression adequately and prevent suicide.

What was the background for the Gotland Project?

In the 70ies we already knew the high mortality in depression-related suicide and that general practitioners were important in the treatment of depression. Despite that taboos concerning the stigma of depression and suicide were weakening, important problems still existed regarding poor diagnostic and treatment routines in primary care and the inability of many depressive and suicidal men to seek help or be recognized. In the 1980s, Gotland had a suicide rate among the highest in Sweden and when I came to the island as Head of psychiatry general practitioners came to me with their concern.

And then what happened?

In 1983–1984 in collaboration with the Swedish Committee for Prevention and Treatment of Depression (PTD Committee) an educational program was introduced for all general practitioners on Gotland. The aim was to increase knowledge about depression and to detect, treat and monitor depressive conditions, not excluding that suicidal processes could be influenced.

We assembled all 21 general practitioners for a 2-day training course supervised by 11 academically and clinically experienced colleagues, with subsequent evaluation. The health authorities on Gotland were supportive and encouraged the general practitioners to participate on duty.

One year later, all participated in a 2-day follow-up course, using a similar model with additional topics proposed in the first evaluation. Both courses comprised lectures, role play, videos and seminars – using a holistic approach avoiding a split between biological and psychodynamic aspects. All lessons were published in two books to the participants.

Wolfgang Rutz
M.D. Ph.D Professor Social Psychiatry,
Coburg, Germany

Thus –the project was initiated as well from "bottom up" as "top down".

What was the impact of the training courses?

The general practitioners identified better patients with clinical depression and treated them more adequately. The unspecific use of anxiolytic and sedative medication decreased and that of antidepressant medication increased. A non-expected result was that the intervention reduced the suicide rate.

Consequences for suicide trends

In the following years, the suicide-rate and inpatient care for depression decreased significantly, as well as the frequency of sick leave. The main result was that early recognition and adequate treatment of depression is one essential method of suicide prevention and that an educational program in primary care was effective. However, the partly dramatic positive results mainly considered females. Male suicide rates were mostly unaffected high.

Why was that?

We did a retrospective clinical analysis of all male suicide victims on Gotland in the decennium before including a "psychological autopsy" with contact to the suicide victims' families, and other relevant persons. These men generally had no contact with the medical system, but often with police, social authorities, addiction care, taxation offices and known as problematic and risk behaving on their workplace.

Violent methods were overrepresented. Most victims had shown a stereotypical clinical picture characterized by acting out, loss of impulse control and destructive aggressive complaining that we recognized as highly suicidal male depressive syndrome, We formulated and published this postulated male depressive syndrome regionally in the mass media, and to sectors of society and included its presentation and discussion in a follow up education in the nineties. For first time even male suicidality on Gotland was reduced.

This finding strongly suggests that the decrease in the suicide rate after the PTD programme is a direct result of the robust decrease in depressive suicides of the area served by trained general practitioners – but that the atypical picture of male depression has to be considered in order to reach maximum outcome.

Long-term effects

The effects of the original project faded after three years. However, repeated educational activities during the 1990s led to a decrease in suicides, also in males.

One conclusion was that problems in finding and treating depressive and suicidal men is due to that they show a clinical picture different from the typical depressive syndrome, but also differences in help seeking and compliance.

During the last decades, the program has stopped, participating doctors have moved, or retired, new focuses prioritized, and suicide rates have unfortunately risen. Societal problems have again increased and with a new generation of general practitioners and psychiatric teachers the continuity is lost. - however, the Gotland's studies educational model and the Gotland male depression scale is used and translated in about 20 countries.

So what can we conclude from this project?

The study illustrates the possibilities, and public health responsibilities of local psychiatric services, but also their limitations. It underlines the importance of a person-centred and gender specific approach, a community based public health focus in preventing suicides as well as the importance of continuous communication, and supervision between primary care and specialist psychiatry. The Gotland study reached its goal at that time. However, to remain effective and fulfil the aims, continuous training and monitoring is required. The fact is that general practitioners as well as psychiatrists in our Scandinavian systems are not stationary and newcomers have to be educated and convinced about the importance of the training. Interested and burning leaders are needed on both sides. This is a huge task. ■

Simulation Teaching of Addiction Medicine in University of Turku

Interview with Solja Niemelä, Minna-Kaarina Wuorela and Valtteri Haliseva

Hanna Tytärniemi

"This is the best teaching method in our medical faculty!" Associate professor Solja Niemelä, teaching nurse Minna Wuorela and actor Valtteri Haliseva have composed an interactive course of addiction medicine for sixth year medical students by using simulation teaching methods. This interview describes what, how and why they are doing with the course and why they are so excited about it.

Turku Simu Center is a simulation center assembled in collaboration between University of Turku, Turku University of Applied Sciences and Hospital District of Southwest Finland. The simulation center provides possibilities for health care professionals and students to practice their skills in exercises reflecting real-life care situations. In this case, mimicking meeting a patient with a substance abuse problem. Actor Valtteri Haliseva is acting a patient who suffers of chronic back pain and uses opioid pain killers excessively. The patient also uses cannabis and benzodiazepines frequently for anxiety and sleep problems. The patient comes to see a doctor to get his prescriptions renewed but the doctor recognizes an addiction problem. "There may be several challenges for the doctor in this situation. How to follow medical guidelines of chronic pain and anxiety problems when the patient is not motivated to stop using opioids or benzodiazepines? How to motivate and attach the patient to a common treatment plan? What is realistic for the first 30 minutes reception?" says associate professor Solja Niemelä.

Simulation teaching is not a new method in the field of medical teaching. In somatic medicine there are doll simulations related to resuscitation or gynecological situations. Use of animal materials is also common in simulating practical handcraft such as suturing stiches or other surgical skills. Sometimes a computer game can simulate certain situations. Simulation teaching in psychiatry requires the use of a live actor. Solja Niemelä emphasizes the connection with the patient: "There is no point in making a treatment plan in which you don't believe as a doctor. First you have to build a liaison with the patient and only then you can start using your academic skills in the doctor's reception."

Turku Simu Center provides excellent conditions for simulation teaching. In this case, there is a doctor's room for a simulated doctor's appointment. The group follows via live audio and video connection and teaching nurse Minna Wuorela gives information and guiding via a loudspeaker. "If the situation requires, I may ask the "doctor" if s/he would like a psychiatric nurse to join the appointment. Then, I enter the room acting as a psychiatric nurse and support the "doctor" as needed." The medical students in this course have already some work experience as a doctor so many of them have already encountered clinical situations like this before. The course also includes some lectures, a web course with clinical examples, simulation pre-study material related to clinical guidelines, a movie related to heavy substance abuse problems and a possibility to visit Alcoholics Anonymous or Narcotics Anonymous group.

Teaching nurse Minna Wuorela puts special emphasis on positive pedagogy: "We try to consider

Dr. Solja Niemelä, Associate Professor (Addiction Medicine), Department of Psychiatry, University of Turku.

Minna-Kaarina Wuorela, Teaching Nurse, Simulation coordinator EuSim, Medical Faculty, University of Turku.

Valtteri Haliseva, freelance actor, drama instructor, Bachelor of Culture and Arts.

all students equally. Each student in the group has an active assignment, e.g. some of them pay attention to patient's or doctor's reactions and body language and others pay attention to the feeling of the situation. We want to put special emphasis on social interaction, self-reflections and counter-feelings and to give our students an experience that they can have an impact on the interaction and how the situation proceeds with the patient." Actor Valtteri Haliseva has a vague manuscript related to the patient's role. "The manuscript changes according to what the doctor is asking and how the situation feels like. For example, if the situation feels confident, I may tell the doctor about the patient's personal problems with his girlfriend. If the doctor confronts me, I may act difficult. As an actor, I am here to support the learning situation, so I try to interpret the student's capacity so that I'm not being too easy or too difficult as a patient." Teaching nurse Minna Wuorela underlines the importance of personal feedback after each simulation. "We avoid giving feedback related to the student's personality factors but instead the feedback may concern how to be more present in the situation or the use of facial expressions or body language."

What may seem like a simple task in study books or exams may become very complicated with a real-life patient suffering of multiple problems. For example, this simulated patient is unemployed, suffers of chronic pain, has anxiety problems and also has some relationship problems with his girlfriend. "It is quite easy to adopt to this patient's role", says actor Valtteri Haliseva. "When a patient has gained a relief from pain with stronger pain killers it is natural for him to believe that it is the best solution and the patient is not very eager to try something else". Solja Niemelä underlines the need for a doctor to keep a professional attitude even if mixed feelings may arise: "Sometimes substance abuse patients deny any addiction problems and they may do almost anything to hold on to their preferred medicine. Sometimes this includes denial, even lying and the use of split. For example, the patient may praise the previous doctor who prescribed large amount of opioids and benzodiazepines and so "helped" the patient more effectively. This split may lead to feelings of guilt or inferiority and the situation may increase feelings of uncertainty." Simulation teaching provides a possibility to reverse the doctor's appointment related to certain difficult parts of the discussion and associate professor Niemelä may even demonstrate a discussion for the group. For example, how to talk about a need to report to child protection services. The students can learn from an experienced doctor about the use of suitable phrases, expressions and body language.

It seems that Solja Niemelä, Minna Wuorela and Valtteri Haliseva are all very excited about this course. "This is the best experience in my teaching career so far", says Niemelä. "Simulation teaching is very rewarding for all participants. Each group is different. Teaching is fun and we have a great atmosphere in the teaching groups. This is an excellent opportunity to give our students a positive and successful experience of a demanding interactive situation." ■

Psychedelic psychotherapy

Tor-Morten Kvam

Randomized clinical trials support the efficacy of methylenedioxymethamphetamine (MDMA) in the treatment of post-traumatic stress disorder (PTSD) and psilocybin in the treatment of anxiety and depression related to life-threatening disease. Psychedelic drugs represent a promising research frontier and have the potential of becoming a part of clinical practice within a few years.

Naturally occurring psychedelic drugs have been used for millennia for spiritual, religious and medicinal purposes. Lysergic acid diethylamide (LSD) and psilocybin were extensively studied between 1950 and 1970, and MDMA was used a few years as an adjunct to psychotherapy until the mid-eighties. All clinical use and research came to a halt due to international bans as response to increasing recreational use and unfavorable media coverage, but the last decade psychedelics have re-emerged within psychiatric research. Research from renowned universities is published in highly ranked journals and both Johns Hopkins University and Imperial College has launched psychedelic research centers.

'Psychedelic' means «mind-manifesting», i.e. causing unconscious material to emerge for analysis and processing. The "classic" psychedelics include among others LSD and psilocybin from 'magic' mushrooms. They are serotonin receptor agonists and primarily stimulate the 5-hydroxytryptamine 2A receptor. Although not considered as a classic psychedelic, MDMA has psychedelic properties and is used within a similar psychotherapeutic framework as LSD and psilocybin. MDMA releases serotonin, noradrenaline and dopamine, and increases levels of neurohormones such as oxytocin. Psychedelic drugs work as catalysts to the psychotherapeutic process, reduce psychological defenses and allows for confrontation of repressed challenging life experiences. Psilocybin increases insightfulness and mental flexibility and stimulates new perspectives. MDMA increases self-compassion, reduces anxiety without emotional numbing, and facilitates trauma processing by providing an increased 'window of tolerance'.

In modern clinical trials, psychedelic drugs are administered in one or a few 6 to 8 hour long sessions as an adjunct to psychotherapy to expedite the psychotherapeutic process. In addition to psychological support during the drug session itself, the participants receive non-drug psychotherapy during preparatory and integrative sessions.

Tor-Morten Kvam
Tor-Morten Kvam is a psychiatrist in an outpatient clinic at the Østfold Hospital Trust, Norway. His research interest focuses on therapeutic applications of innovative treatments such as MDMA, psilocybin and ketamine. He is a co-founder of the research group PsykForsk and is currently a therapist in the European phase 2 MDMA-assisted psychotherapy for PTSD trial. He is also a board member of the scientific association Norwegian Psychedelic Science.

During the preparatory sessions, the therapists gather participant history, educate the participant about what to expect during the drug sessions and begin establishing an effective therapeutic alliance. During the drug session, the participant rests in a comfortable room and is encouraged to focus on introspection, listen to music and wear eyeshades. A male and female therapist pair supports the participant

During the session, the patient rests in a comfortable room

throughout the session. The therapists use a nondirective and supportive approach, listen empathically to the patient, and facilitate a sense of safety and trust. During the integration sessions, the therapists work with the participant to analyze and interpret the content of the psychedelic experience, and help the participant apply any benefits gained in the drug sessions to daily life.

Modern clinical trials suggest that psychedelic drugs have few adverse effects in a controlled clinical setting. No serious adverse events have been reported except one individual in an MDMA-assisted psychotherapy for PTSD trial who experienced an exacerbation of pre-existing premature ventricular contractions which resolved completely without sequelae. The risk of adverse events is mitigated by careful screening of individuals, the use of strict inclusion and exclusion criteria, and psychological support during preparation for the trial, the experimental session itself, and the integration work that follows, in adherence with published guidelines for the safe conduct of psychedelic clinical trials.

Although various psychedelic drugs have shown promising results for the treatment of psychiatric disorders and substance use disorders, it is psilocybin and MDMA that has the most extensive data. The American Food and Drug Administration has granted MDMA-assisted psychotherapy for PTSD and psilocybin-assisted psychotherapy for treatment-resistant depression "breakthrough therapy designation", suggesting the therapies represent improvements over existing treatment, as well as providing regulatory priority.

Psilocybin-assisted psychotherapy has been demonstrated to reduce existential distress, anxiety and depression related to life-threatening disease. The two largest double-blind randomized controlled trials (DB-RCTs) with 80 participants in total showed immediate and sustained efficacy for at least six months from a single psilocybin session combined with psychotherapy with large effect sizes. One long term follow-up study demonstrated sustained effects 3-4.5 years later. Furthermore, a randomized, waiting list controlled trial investigating psilocybin in 27 participants with major depressive disorder has just recently been published in JAMA Psychiatry (A. K. Davis et al. 2020). Two psilocybin sessions with psychological support demonstrated immediate effect that persisted at least four weeks with large effect sizes. According to Clinical Trials, there are four actively recruiting DB-RCTs investigating psilocybin-assisted psychotherapy for major depressive disorder (N=80; N=60; N=18) and treatment-resistant depression (N=216), respectively.

More than 100 participants with moderate to severe and largely treatment-resistant PTSD have been enrolled in six randomized controlled phase 2-studies with MDMA-assisted psychotherapy. PTSD symptoms were significantly reduced 1 to 2 months after two or three MDMA sessions with large effect sizes. At the 12-month follow-up, 67 % of the participants no longer met the criteria for PTSD. Three multisite DB-RCT phase 3 trials with a total of 270 participants are now underway. An interim analysis from one of these demonstrated at least 90 % chance of statistically significant results after trial completion.

Psychedelic drugs are making a comeback in psychiatric research, and their therapeutic potential will largely be determined by the completion of ongoing clinical trials. If the existing results can be confirmed, the immediate and sustained efficacy of a single dose will introduce a new principle in psychiatric treatment. Sustained efficacy of a single dose or a few doses would be beneficial compared to the daily administration of drugs and the associated adverse effects. The Nordic countries are well represented in several high-quality trials investigating psychedelic drugs in the treatment of mental disorders. This requires financial support, either from pharmaceutical or governmental funding sources, as well as institutional support, and a significant apparatus for obtaining the necessary approvals internally in the hospitals and universities, as well as from the regulatory authorities. ■

Practical Aspects of Esketamine Use

Interview with Dalia Gudeikiene and Case Presentation

Ramunė Mazaliauskienė

Foreword by Ramune Mazaliauskiene

In Lithuania we had a clinical trial with the use of esketamine in elderly. In late 2019 there appeared a possibility to start esketamine programs in psychiatric institutions. This treatment is fully compensated by the state. There are two centres in Lithuania in which esketamine program is performed. Psychiatric clinic at Lithuanian Health sciences university Kaunas hospital is one of such places. Below you will find two patient cases presented by Dalia Gudeikiene – a person who takes an active role in the implementation of the program and in practical clinical work with patients who suffer treatment resistant depression and who is prescribed esketamine.

Dalia Gudeikiene
is a psychiatrist and psychotherapist. She has a more than 20 years lasting practice as a psychiatrist, and for many years she is interested in the treatment of depressive disorders. She is a head of Depression treatment ward in Lithuanian Health sciences university Kaunas hospital. She works in one of two centres in Lithuania that implemented esketamine program for patients who suffer treatment resistant depression.

R. M. How did you start to use esketamine?

D. G. The first acquaintance with esketamine was in a clinical trial, although at the time of the study, it was not known whether the patient was receiving a placebo or a medication. Later, when we started using esketamine in practice, I already had some experience, and a lot of scientific material was analysed. So, I knew what to expect.

R. M. What are your first impressions?

D. G. However, the first impression is that its effect is rapid, different from other medications used to treat depression. Another interesting observation: esketamine enhances the emotion with which the patient comes to the visit during which esketamine is administered. If you come up with good thoughts, then after taking esketamine for a while everything can be very funny. If you come up being angry, you may cry for an entire hour or even start screaming. Interestingly, such side effects occur within the first hour and then disappear completely, and the patient remembers them. They are most pronounced at the beginning of treatment with the introduction of esketamine into the treatment regimen. Therefore, the tension at the beginning of treatment is always higher. Later, when the patient switches to long-term regular use of esketamine, these reactions are almost non-existent.

R. M. Were you worried or afraid to start using an "un-known" medication having a new mechanism of action and unexpected side-effects?

D. G. As I mentioned, you don't always know how it will be in the beginning, but you always know it

will be temporary and will definitely go away. I think the stability of the professional himself and the confidence that he will manage the situation is very important, because the patient is worried or even afraid at the beginning.

Case No. 1.

Female Patient about 25 years old. Limited working capacity due to Recurrent Depressive Disorder (F33.2). Suffers depression from 22 years of age. 18 times treated in psychiatric hospitals. Medication treatment is ineffective, medication often changed due to side effects. In the fall of 2019, the patient's condition was described as treatment-resistant depression. The patient was prescribed venlafaxine 75 mg/day and involved into esketamine treatment programme.

First use of esketamine. The patient came on an empty stomach for 2 hours and without fluids for 30 minutes. Slightly worried and tense. Arterial blood pressure 129/86 mmHg, heart rate 75 bpm.

10:30 Patient self-injected a prescribed vial of Esketamine 28mg into the nose.

10:35 Arterial blood pressure 115/87 mmHg, heart rate 74 bpm. The patient self-injected the prescribed 2nd vial of Esketamine 28mg into the nose.

10:45 The patient sits with her eyes closed, feeling bitterness in her mouth. It feels like the whole body is disconnected. She feels "brighter" in her head, and pessimistic thoughts disappeared. She closes her eyes, smiles, and falls asleep.

11:05 Starts laughing. She says that it is very funny to hear the chirping of a bird outside the window.

11:15 Patient says she wants to cry. Starts crying. After that she laughs again.

11:35 Speaks continuously without interruption. No more crying.

11:45 Laughs loudly.

11:55 The patient calms down. Accompanied to the ward, she lays down.

12:00 Feels good. Arterial blood pressure 129/90 mmHg, heart rate 80 bpm.

Case No. 2.

Male patient. Working about 60 years old. Diagnosed with Recurrent depressive disorder (F33.2). Depression has been present since the age of 17. Attended psychotherapy. At the age of 22, he consulted a psychiatrist for the next aggravation. Treated with Mirtazapine 30 mg / n, Bupropion 300 mg / day. At the age of 25, there was a recurrence. He was prescribed Mirtazapine 30 mg / n, Bupropion 300 mg / day, followed by Agomelatine 25-50 mg/ night. The patient remained depressed, without the joy of life, lonely, socially isolated, lacked energy and ability to work. Mental status did not improve, resistance to drug treatment developed. The patient found out about the possibility of receiving esketamine treatment - even before starting the esketamine program in Lithuania. He waited until this treatment was available.

First administration of esketamine. The patient came on an empty stomach for 2 hours and without fluids for 30 minutes. Arterial blood pressure 127/73 mmHg, heart rate 69 bpm.

09:00 Self-injected 28 mg of Esketamine 1 vial into the nose.

09:05 Arterial blood pressure 115/76 mmHg, heart rate 64 bpm. He self-injected a second vial of 28 mg mg of Esketamine into his nose.

09:10 Arterial blood pressure 120/75 mmHg, Heart rate 60 rpm. He self-injected the prescribed third vial of Esketamine 28mg into the nose.

09:20 The patient is happier, feels bitterness in the mouth. The patient hears everything more clearly, and feels hungry. Experiences a slight melting of his face.

09:30 The patient feels healthy. More fun. Talks a lot about himself about himself.

09:40 The patient is calm, feeling good. Chats, communicates.

09:50 The patient smiles, the numbness is gone.

10:00 Feels good. AKS 125 / 76mmHg, SSD 67 bpm.

During treatment, the patient's mental condition improved. The patient was discharged from the Depression Treatment Unit at home with esketamine 84 mg once weekly and agomelatine 5 mg / n for outpatient treatment.

A case of Post-Covid Encephalopathy

Maher Khaldi

A man of Swedish origin was admitted to a psychiatric clinic. He was complaining of feeling drowsy , foggy- like feeling in the head, difficulty thinking clear , loss of smell and taste sensation , feeling unreal and a sense of depersonalization. 5 days prior to this he was discharged from the medical ward at the same hospital after being treated for Covid infection for 7 days at the Department of infectious disease.

Maher Khaldi
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During his stay at the department he received only oxygen treatment , prophylactic anticoagulation with Fragmin injections and even received Dexamethason 6 mg x1 and Remdesivir during his stay at the Department of infectious diseases. The Covid infection was confirmed through blood tests and CT-Thorax with the classic glass-ground opacities with pulmonary consolidation. The patient was living together with his partner. He did not smoke and drank only on occasions. He had a past history of a single depressive episode for more than 10 years ago which was treated by his primary care physician. There was no family history of serious mental illness.

On examination on the next day the patient showed a clinical picture which is reminiscent of a Parkinson-like .The patient showed a very slowed gait and loss of arm-swing while walking. His speech was very slowed and he had problems talking , formulating answers to questions and he had clear cognitive slowness. He had clear troubles thinking and formulating his thoughts. He was very frightened and managed to report that he felt very old! On neurological exam besides the gait and speech problems he showed only loss of reflexes in both arms and legs with no lateralization. Clinically it looked like a case of hypodopaminergism . A comprehensive blood test panel showed only increased homocysteine levels for which he received B12 +Folat pills .MRI of the brain was normal. EEG exam revealed on the other hand a clear but unspecific pathological pattern with irregular rhythms and even epileptiform activities over the frontal and bitemporal regions. A neurological consultation was done and recommended lumbar puncture to exclude encephalitis .A wide test panel was done and sent to the lab. The patient was put on a prodopaminerg medication Modafinil 100 mg daily. Preliminary results of the LP showed a minor inflammatory state but no evidence of any serious bacterial infection. Clinically the patient did well on Modafanil treatment and restored his speech and thinking ability and improvement of Gait. A second control with a renewed EEG exam after 5 days showed clear improvement and resolution of the pathological patterns in the previous EEG. The patient was discharged to home on the 13 day of admission . The extended lumbar puncture panel was negative! ■

A Modest Art of Table Making: Week of the Manager during the Times of Pandemic

Ramunė Mazaliauskienė

Monday.

The early morning begins with a referral from on-duty psychiatrists from the three sectors of the Psychiatric Clinic. No major events, just daily routine worries: ambulance and police crews complain of having to wait in a long line for admission to the Admission-Emergency Department, and delays in Covid-19 test responses from the lab again.

We start the morning with the Table No. 1 for the clinic staff who have to make a regular check for Covid-19. It is performed once in a month for every medical staff member. For the second consecutive week, we're doing it on our clinic's premises; everyone is very happy

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as there is no need to waste time and go to a much more distant points in order to have the test.

The administrator of the Admission-Emergency Department informs about a new case of Covid: during the preventive examination a positive result was obtained by one of the employees of the department. The staff member was on duty in one of the psychiatric wards a couple of days ago. We fill in her contact list (Table No. 2) and send it to the responsible infection control specialists. In parallel, we are looking for replacement for a colleague lost in the fight of pandemic control. As the pandemic accelerates and the number of cases increases, it is becoming increasingly difficult to find staff for replacement.

A short break in a form of access to the drug demand tables for 2021 sent by the departments of the Psychiatric clinic (A set of Tables No. 3). There is no time to go deep into their needs, so, the tables quickly are sent to the central pharmacy department.

We send the Tables (No. 4) to the "Call Centre of the hospital" - drawn up in a way that suits them - with the working schedules of the psychiatrists. These lists are necessary in case of some urgent need of a consultation.

In the afternoon, together with the clinic's chief nursing administrator, one psychiatrist, and one nurse, we work on staff financial incentive Tables (No. 5). Each clinic has an amount of money allocated for staff promotion. Dividing money is always an enthusiastic action, there are still a lot of emotions that arise when the calculated amount does not match the one assigned. For some reason, we get more than we intended all the time. All amounts go to the staff promotion tables together with the surnames of the workers, and the tables are sent to the economics department.

Psychiatric departments have already sent in their equipment needs for 2021; the latter need to be broken down into different tables. One - for fixed assets (Table No. 6). It must be distinguished from short-term (Table No. 7). Criteria are two: price (more than 500 E) or durability. IT technology needs to be selected from the above table in a separate Table (No. 8). A great task for a person with a medical education, but my knowledge about the prices of patient strollers, functional beds, and other ammunition is expanding significantly. Gradually, three separate tables seem to be born soon.

However, it is not possible for them to be born because the tables for the provision of services in September (Tables No. 9) fall into the e-mail. They need to be read carefully as they will be analysed at tomorrow's management meeting; you need to be prepared to answer a variety of questions.

Before going home with the clinic's nursing administrator, we review the Table (No. 10) sent by the infection control specialist with the names of the staff and the self-isolation measure indicated. We check to see if the staff mentioned really left home to self-isolation.

The table with the list of quality management procedures needs to be updated (Table No. 11) by moving the procedures to a new grid representing an already new hospital, and the table of drug use in September received from the central pharmacy (Table No. 12) are waiting for quieter times.

Several hours of practical medical psychiatrist-psychotherapist work in a private clinic. It would be a real refreshment if not the need to wear a mask. I feel short of breath, patients seem to be too. Patients complain less, I give less feed-back.

In the evening, I prepare dinner for the family, listening to the TV news in parallel.

I respond briefly to letters often related to the activities of the Psychiatric Association.

Evening at home with knitting and book...

Tuesday

Reporting of on-call doctors on on-call events. Nothing new.

We compile a table of staff who have to perform a regular check for Covid-19.

I am looking at the table of medication use in September by the psychiatric wards. Again, the amounts are exceeded, which is not surprising given the number of protection and disinfection measures used.

I am going to a management meeting; it takes place in another building of the hospital, about a 20-minute drive away. At the meeting I learn that an amount of EUR 10 million has been allocated to a psychiatric clinic – new building will be built in approximately 5 years. I suspect that there will be a lot of new tables to be prepared during this period.

We continue to work with tables No. 6, No. 7 and No. 8. Evening with e-mails, knitting, book…

Wednesday

Early morning wake-up call. At 6.15 comes a short message from one of the heads of the psychiatric wards. Her child is diagnosed with Covid plus, and she has to insulate herself for two weeks. Immediate actions are required as she is an administrator, and a psychiatrist, and – at last, but not the least - a doc-

tor who has to be on-duty tomorrow. Phone calls and discussions with the colleagues who can perform her duties. The table of her contacts has to be postponed until information of her own Covid-19 test results.

At normal time in the morning: reports of on-call doctors on the events of the day and night. Nothing new, just daily routine problems.

We compile a table of staff who have to do a routine check for Covid-19.

And then the time for some 4th year medical students comes. Most of education is on-line now. Only practical work of psychotherapy course is still a live one. But todays 'module is an on-line one. I open "teams" platform. Some of the students are already here. What I see is some sort of a big table with small windows and initials of the participants. They are very very silent. "Good morning ", I say. "Is there anybody out there? "There is silence lasting a few seconds, and then one far away voice answers „Yes". Glad to have at least one listening participant I start a discussion about psychotherapy and psychosocial rehabilitation.

After work, I run to the filming studio - a distance conference for family doctors. The facilitator sits in one corner of the hall, I sit in the other corner. Operator is not visible at all. Pandemic work reorganization.

Thursday

I am driving to another unit of the clinic, which is 25 km away from the first one.

Reporting of on-call doctors on on-call events. Nothing new.

We compile a table of staff who must make a routine check for Covid-19.

We are filling out a new contact table for staff member Covid-19.

We analyse drug use tables with department heads.

We analyse drug and disinfectant consumption tables with the nursing administrator.

We discuss laundry tables with the Head of nursing.

We analyse the table of statistical results of the departments with the heads of the departments.

I correspond with the chief of the computer department; I address him in English, Russian and Simplified Chinese – in order to draw attention. They receive a lot of questions and complains, so, you must try hard in order to be noticed.

There is a new e- mail requesting to organize meetings of staff in every department of the clinic in order the select a person from each department. That person will participate in election of representatives of ethical committee of the hospital. This doesn't seam very wise in times of pandemic when all the bigger meetings are restricted or forbidden. And it seams to be a good opportunity to have the whole department with Covid infection after such meeting. After some discussions we are allowed to organize distance meetings.

"Teams" meeting with the Ministry of Health; a working group has to finalize a table of mental disorders that are incompatible with driving licence.

Friday

Reporting of on-duty doctors on on-call events. Nothing new.

We compile a table of staff who have to be monitored for Covid-19.

Computer scientists bring 4 computers; asks to send a table how they will be distributed.

The quality management newly made papers (the new is the old thing that had to be reviewed and put on a new template) come back as the new template was not correct. It was changed somewhere in the process, and nobody informed us about the change.

We continue to work with the tables No. 6,7,8.

In the afternoon there is an editorial meeting of "Nordic psychiatrist". Not live, of course. We have to review the table of scheduled articles.

Saturday

Lovely cosy Saturday breakfast without rushing anywhere. At the table, but without tables. I slide around the yard, then my husband and I go out in search of flower pots. There are no less people in the shops, but all with masks, keeping distances. They look at each other with some suspicion.

After family lunch, I am preparing for next week's student seminar and Young Psychiatrists Conference, where I will be reading a report on telepsychiatry.

An evening with a primitive and no intellectual activities requiring detective on TV.

Sunday

Morning coffee, early afternoon coffee, late afternoon coffee, early evening coffee... I work hard with a weekly table about the tables that have to be created / reviewed / edited in the next week. Just to be in time with all the deadlines. Sunday is a little Monday. ■

Highlights from the Nordic Journal of Psychiatry

Martin Balslev Jørgensen

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

Experience of social cognition in Ultra-High Risk of psychosis

Impairments in social cognition (SC) have been reported in people at Ultra-High Risk (UHR) of psychosis. This study assesses subjective experience of SC in a UHR group, explore associations of SC with psychopathology and functioning; and to monitor longitudinally the SC stability at 2-year follow-up. Participants completed the Comprehensive Assessment of At-Risk Mental States (CAARMS) and the GEOPTE scale of social cognition for psychosis. In comparison with non-UHR/FEP, both UHR and FEP subjects showed significantly higher GEOPTE scores. Both after 12 and 24 months of follow-up, UHR individuals had a significant decrease in severity on GEOPTE SC subscore. In the UHR group, GEOPTE scores showed significant positive correlations with general psychopathology, positive and negative symptoms. Regression analysis showed a significant contribution of SC in predicting baseline social isolation, impaired role functioning, and general psychopathology. After 1 year of follow-up, improvement in SC was predicted by the number of psychotherapy sessions and lower doses of antipsychotics. The authors conclude that SC deficits are prominent in UHR individuals and are similar in severity to those of FEP patients. However, they tend to decrease over time along with the delivery of targeted, specialized interventions for early psychosis.

Pelizza L, Poletti M, Azzali S, Garlassi S, Scazza I, Paterlini F, Chiri LR, Pupo S, Raballo A.
Subjective experience of social cognition in young people at Ultra-High Risk of psychosis: a 2-year longitudinal study *Nord J Psychiatry 2020 Aug 7;1-12. doi: 10.1080/08039488.2020. 1799430. Online ahead of print. PMID: 32762506*

Ketogenic diets in the treatment of central nervous system diseases

Evidence suggests that KD could be used in the treatment of central nervous system (CNS) diseases. This

systematic review investigates the use and efficacy of KD, modified Atkins diet (MAD) and medium-chain triglyceride (MCT) diet in infants, children, adolescents, and adults with CNS diseases. The review was performed according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. Only randomized clinical trials (RCTs) were included and only if they reported KD, MCT or MAD interventions on patients with CNS diseases. Twenty-four publications were eligible for inclusion (n = 1221). Twenty-one publications concerned epilepsy, two concerned Alzheimer's disease (AD), and one concerned Parkinson's disease (PD). All studies regarding epilepsy reported of seizure reduction compared to baseline. MCT did not significantly change regional cerebral blood flow (rCBF) in patients with AD, but MAD significantly improved memory at 6 weeks. KD significantly improved motor and nonmotor functions in patients with PD at 8 weeks. There was a trend towards fewer adverse effects in MAD compared to KD. The authors conclude that various forms of KDs seem tolerable and effective as part of the treatment for epilepsy, AD and PD, although more investigation concerning the mechanism, efficacy and adverse events is necessary.

Christensen MG, Damsgaard J, Fink-Jensen A.
Use of ketogenic diets in the treatment of central nervous system diseases: a systematic review. *Nord J Psychiatry. 2020 Aug 6;1-8. doi: 10.1080/08039488.2020.1795924. Online ahead of print.*

The relationship between attachment and functioning for people with serious mental illness

Functional impairment is a hallmark feature of severe mental health problems. Attachment theory is a key psychological theory of interpersonal functioning and difficulties in attachment are common in SMI and may help explain functioning problems in SMI. This systematic review synthesizes and critically appraise existing literature. Ten studies met inclusion criteria. Considerable heterogeneity was found across studies in relation to construct measurement, sample size, and gender distribution. However, there was some evidence to suggest that secure attachment is associated with better functioning, and insecure attachment (specifically anxious style) is associated with impairments in functioning. The authors conclude that the findings highlight the importance of considering attachment in relation to functional outcome when working with people with SMI, particularly when assessing, formulating, and delivering psychological interventions

Pearse E, Bucci S, Raphael J, Berry K.
The relationship between attachment and functioning for people with serious mental illness: a systematic review. *Nord J Psychiatry 2020 Jul 21;1-13. doi: 10.1080/ 08039488.2020.1767687. Online ahead of print.*

The role of entrapment in poor treatment outcome in major depressive disorder.

Only a small number of consistent processes predict which depressed patients will achieve remission with antidepressant medication. Defeat and entrapment predict poorer response to antidepressants. However, results are inconsistent. This study evaluates evolutionary strategies, childhood maltreatment, neglect and life events and difficulties (LEDs) as predictors of remission in depressed patients undergoing pharmacological treatment in a psychiatric outpatient sample. A cohort of 139 depressed outpatients undergoing pharmacological treatment was followed prospectively in a naturalistic study for 6 weeks. Patients were allocated to a pharmacological treatment algorithm for depression - the Texas Medication Algorithm Project. Variables evaluated at baseline and tested as predictors of remission included demographic and clinical data, severity of depression, social ranking, evolution informed variables, LEDs and childhood maltreatment. Of the 139 patients, only 24.5% were remitted at week 6. Non-remitted patients scored significantly higher in all psychopathology and vulnerability scales except for submissive behaviour and internal entrapment. A higher load of LEDs of the entrapment and humiliation dimension in the year before the index episode and higher levels external entrapment in the Entrapment Scale predicted non-remission. These variables accounted for 28.7% of the variance. The authors conclude that multivariate analysis revealed that external entrapment was the only predictor of non-remission

Carvalho S, Caetano S, Pinto-Gouveia J, Mota-Pereira J, Maia D, Pimentel P, Priscila C, Gilbert P.
Predictors of poor 6-week outcome in a cohort of major depressive disorder patients treated with antidepressant medication: the role of entrapment *Nord J Psychiatry 2020 Jul 10;1-11. doi: 10.1080/08039488.2020.1790657. Online ahead of print.* ■