THE NORDIC PSYCHIATRIST

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Individualized medicine

NORDIC PSYCHIATRIC ASSOCIATIONS

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

Dear colleague,

How would you describe your clinical work? Would you say that your practice is evidence-based or rather that you individualize treatment according to the needs of the patient? What is actually the meaning of evidence-based clinical practice? The "one size fits all" approach does not work in the real world. We cannot strictly adhere to treatment algorithms but have to consider a number of factors before deciding on a particular treatment strategy. In this context is there a risk of moving from evidence-based medicine – to evidence biased?

The world of medicine has of late seen a number of trends. During the last decade we have gotten acquainted with terms such as "person centered care" (especially in Sweden, where nobody really understands what it actually means), "public management in healthcare" and "personalized medicine". How would you describe the latter? This term has different connotations, integrating evidence-based guidelines with individual patient characteristics including genetic and social aspects in making diagnoses and tailoring treatment. In this issue, we try to bring some clarity to the concept of "personalized medicine".

In our last issue, we wrote about when illness affects physicians themselves. This issue was met with lots of interest, which is of course understandable. As doctors, being a patient oneself or treating a sick colleague comes with it's own special concerns. In this issue we have a colleague, writing about his own long journey with depression and the process of recovery.

This journal is the voice of the Nordic and Baltic psychiatric associations, a collaboration spanning more than a century. We always strive to find subjects that are of interest to the most of us and to learn from experiences from our neighboring countries. Therefore, there is an ongoing dialogue with each national association to identify subjects that interest us who practice psychiatry in this part of the world.

Hans-Peter Mofors

In order to deliver a better journal, we will now change its structure, introducing separate sections. We will in the future always highlight educational perspectives, pivotal moments in psychiatric history and commentary about current issues in psychiatry. Furthermore, I invite you, the readers to suggest articles. Maybe you yourself want to contribute, or know someone who would like to?

Our next issue will have focus on "Arts and Culture in psychiatry" – a huge and highly interesting topic. Please write to me and suggest articles. Let us together create an exciting issue on this topic! But for now, let's focus on the present. This issue is filled with many interesting articles. Read, reflect, share and let me hear your reflections!

Best regards,

Hans-Peter Mofors,
Editor

The future of psychiatrists

Ulrik Fredrik Malt,
President of the Nordic Psychiatric Associations

The last two decades has been characterized by a flow of *neurobiological* research in psychiatry including genetics. Brain network and genome wide association studies of mental disorders are on the rise. Studies merging neurobiological data from different research groups into huge databases including 100.000 patient data or more, report "statistically significant findings". However, neither neurobiological nor genetic research have provided information useful in clinical practice. In psychopharmacology, all recently marketed drugs are based on traditional mechanism of actions.

We have also witnessed a vast number of "new" *psychotherapies* being launched (e.g. Mindfulness, Meta-cognitive psychotherapy, Acceptance and Commitment Therapy, Dialectic Behavioral Therapy). But again, most new therapies are just variation of cognitive psychotherapy with modest effect sizes (e.g. about 0.4), i.e. not different from that of "older" psychotherapies.

Furthermore, despite initial enthusiasm, evidence-based medicine has turned out to have several limitations. It relies heavily on meta-analyses of randomized controlled studies, results emphasizing the "median" patients. Clinical experience and data from longitudinal observation studies, are not considered to have enough "validity". Thus, guidelines based on meta-analysis have strengthened "one size fits all" psychiatry. The person behind a diagnostic label is fading away.

And not the least: By use of internet and social media, our *patients* are much more updated on current controversies in psychiatry and available treatments, and thus more likely to request specific interventions or challenge our suggestions, than one decade ago. However, they do not have the basic knowledge to differentiate facts from fake and to grasp the overall picture.

So, what is the future? First, we will never be able to erase mental disorders. Thus, though neurobiological research may offer promises for more specific personalized interventions in the future, we **will still need good clinicians** that may integrate all available data into a comprehensive treatment. Second, technology may improve diagnosis (e.g. Facial Image Analysis Technology, artificial intelligence) and treatment without human contact (e.g. internet-based therapies, woebots). But the most severely affected patients still will need to interact with a human, not to a smartphone or a computer. Third, we will encounter increased competition from other professions. There is no research evidence that effectiveness of psychotherapy conducted by psychiatrists is better than psychotherapy conducted by devoted primary care physicians, psychiatric nurses or clinical psychologists. And you do not have to be a psychiatrist to conduct "guideline based" psychopharmacology.

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

What can we do? As psychiatrists, we have the potential simultaneously to address both the biological and psychological aspects of mental disorders. I.e. we should have basic skills needed to take care of the "whole" person at the same time. But in order to do so, we must be updated not only in psychiatry, but also have updated knowledge in basic medical issues, in particular internal medicine and neurology. Now is the opportunity for us to change and grow. In ten years, it may be gone. Grasp it! ■

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Why we need person centered medicine

Interview with Professor Juan Mezzich

Marianne Kastrup

Juan Mezzich is Professor of Psychiatry and Director of the International Center for Mental Health at the Icahn School of Medicine at Mount Sinai, New York. He has authored over 400 scientific articles and book chapters and more than 30 books and monographs. Juan Mezzich has played a key role in international psychiatry and medicine, as President of the World Psychiatric Association in 2005-2008 and founding President 2009-2013 and now Secretary General of the International College of Person Centered Medicine.

JM opening: We need person centered medicine because we need to understand illness and positive health from the perspective of the person of the patient, and to place such person as the goal of health actions. We must also recognize the persons behind health professionals, families and community members. This involves ethical commitment, a holistic theoretical framework, cultural awareness and responsiveness, individualized care protocols, a communication and relationship matrix, collaborative diagnostic understanding of the patient's clinical situation and shared decision making, community-centered organization of services, and person-centered professional education and health research. Person centered medicine proposes a medicine informed by evidence, experience and values, and oriented to the promotion of the whole person in context.

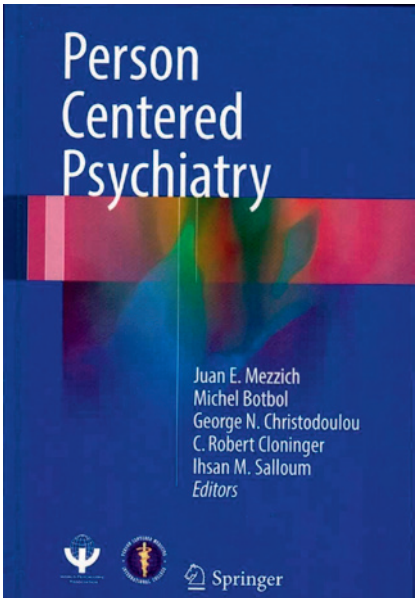
MK: What was the background for your interest in person centered medicine?

When I started my WPA Presidency in 2005 I had the opportunity to launch a presidential theme on psychiatry for the person. This perspective involved a psychiatry *of* the person, *by* the person, *for* the person and *with* the person. This also involved the articulation of science and humanism, recognizing that science is essential, while humanism is the essence of psychiatry and medicine.

MK: How was this person-centered approach received by the psychiatric community?

The cultivation of this perspective became WPA's first institutional program. Many of our Scientific Sections organized symposia and publications by applying this perspective to their Sections' fields. Also several of our national member societies organized conference with themes related to this perspective. Furthermore, other global professional associations, such as the World Federation of Neurology and the World Organization of Family Doctors communicated with us and decided to introduce this perspective in their work.

MK: And once your WPA Presidency ended how did this thematic program move forward?



Juan Mezzich
Professor of Psychiatry and Director of the International Center for Mental Health at the Icahn School of Medicine at Mount Sinai, New York

We were pleasantly surprised to discover that the World Medical Association, the International Council of Nurses, and the World Health Organization were all ready and enthusiastic to collaborate with us. In cooperation with these and other international institutions, we have been holding annual Geneva Conferences since 2008. Their main themes have covered the articulation of concepts and actions, inter-professional team work, the relationship between clinical medicine and public health, and more recently have addressed the promotion of well-being and overcoming burn-out.

MK: Has this initial grass-root movement become more professional now?

From the Geneva Conferences emerged an International Network, now International College of Person Centered Medicine. It has a multi-disciplinary Board involving physicians of several specialties, nurses, and patient organization representatives. Since 2013 we have been additionally holding International Congresses of Person Centered Medicine, the first one in Zagreb, the latest one in New Delhi, and an upcoming one in Tokyo, typically hosted by the corresponding national medical associations. We have also regional networks, such as a very active one in Latin America. This has already organized four annual conferences and has supported the development of a Latin American Guide for Psychiatric Diagnosis issued by the Latin American Psychiatric Association, using ICD categories and codes and a cultural informed and person-centered diagnostic formulation.

MK: Do you have any publication activities?

Since 2012 all our Geneva Conferences and International Congresses issue *Declarations* on their main themes which are then published in our website and various journals. In collaboration with the University of Buckingham Press we have initiated an *International Journal of Person Centered Medicine*. In cooperation with Springer International, we recently published a textbook on *Person Centered Psychiatry* (cover enclosed). We are now preparing a second textbook on *Person Centered Medicine,* and we plan to do next a third one on *People-centered Health Systems*.

MK: How would you describe the potential benefits for patients of the person-centered approach?

I believe that by using this programmatic perspective, you communicate with patients more effectively and in a more respectful and empowering manner. Secondly, you have a broader and more contextualized framework for understanding illness and health and for undertaking health actions. Thirdly, you not only treat illness collaboratively, but also seek to promote positive health and stimulate patients to cultivate their own life projects. With a person-centered approach benefits seem to emanate not only for patients but also for families and for health professionals themselves. ■

Why should we talk about pharmacogenomics?

Interview with Edgaras Dlugauskas

Ramunė Mazaliauskienė

Many years has passed since the time when listening to and watching our patients were the only means to make a psychiatric diagnosis and try to predict the effect of the treatment and outcomes. Modern medicine has given us some new tools, but how can we use it? what are the possibilities and restrictions of the pharmacogenomic testing in psychiatry? These and some other questions will be answered in the interview with Edgaras Dlugauskas.

R.M: So, why should we talk about pharmacogenomics in psychiatry?

E.D: Well, it is known that there are over a hundred different medicines used in psychiatry. However, patient response to standard psychotropic medication doses is different and individual. Only 25% to 60% of cases of medical treatment are successful when using standard doses of medication.This is a serious medical problem in everyday practice – an individual response to the treatment may occur in insufficient treatment efficiency, serious side-effects or unexpected interactions with other drugs. It is believed that this may be due to various factors: age, sex, morbidity, a poor doctor-patient relationship, as well as due to medications interactions, nutrition and smoking habits. However, one of the essential reasons is the CYP450 enzyme system, responsible for the metabolism of many drugs and gene polymorphisms. The CYP450 enzyme activity determines the metabolism of drugs and is one of the most important determinants of the concentration of drug in the plasma. The activity of the enzymes depends on the genotype and its polymorphisms. Due to the differences in genetic variation of enzyme activity – drugs' plasma concentration may vary even up to 1000 times. But the good news is that now we can find such polymorphisms and therefore help our patients.

R.M: Are there any research data to illustrate how serious this problem might be?

E.D: According to the meta-analysis published in the United States, a frequency of severe side effects sometimes reaches 6.7% and is responsible for 100 000 deaths every year. We don't have exact numbers in Europe, but it is known that about 10–20% of the Europids' CYP superfamily genes are changed. We do not have data on the situation in Lithuania, so exact figures are unknown as well.

R.M: Why should we consider pharmacogenetic testing in our daily psychiatric practice, and what is the current situation with practical use of this method?

E.D: Pharmacogenetics is a rapidly developing branch of genetics; its results are directly applicable in everyday clinical practice. The practical value of pharmacogenetic tests is increasing each year. Pharmacogenetic tests have been successfully adapted for the individualization of treatment in the areas of cardiology, endocrinology, and oncology. In the field of psychiatry pharmacogenetic tests may enhance the patient's treatment efficiency and reduce the excess medical costs of adverse drug reactions. In Lithuania, molecular genetic tests of drug metabolism are already being done, which allows for selecting the drug and its initial dose more precisely. Academia is becoming more and more focused on pharmacogenetic research and drug metabolism, but any detailed work linking genetics and clinical outcomes is not plentiful. Now, pharmacogenetic studies are mostly used retrospectively – when attempting to explain the atypical (inefficient or toxic) response to treatment cases.

R.M: Talking about psychiatric patients and treatment – what kind of information can we get from pharmacogenomic testing?

Edagras Dlugauskas MD, PhD, is a psychiatrist and psychotherapist; he works at the University hospital in Vilnius. This year he defended his dissertation "The Influence of CYP2D6 and CYP2C19 Gene Polymorphisms on the Clinical Efficiency of Antidepressants in Treating Moderate and Severe Depression".

E.D: Recent studies show that the CYP450 enzyme genotype determination may provide significant information about psychotropic medication metabolism rates. The goal of this thesis is to determine how CYP450 gene *(CYP2D6* and *CYP2C19)* polymorphisms lead to the clinical effectiveness of antidepressant response in moderate and severe depression. Therefore this testing helps a psychiatrist to choose the medicines and their doses purposefully rather than empirically. One must bear in mind that CYP gene polymorphism frequencies in depressed people are significantly different from healthy individuals and other mentally ill patients.

R.M: Who can benefit from pharmacogenetic testing?

E.D: The treatment is effective when applying drugs in usual dosages only within a range of 30–60% of all cases. When selecting the treatment, the individual genetic and biochemical properties of the person are usually ignored, so patients may be falsely attributed to having treatment-resistant depression or be exposed to dangerous side effects of the prescribed drugs. These are two main groups of the patients with greatest benefit of such testing. Nevertheless, with the emergence of new opportunities to analyze the human genome, as well as the introduction of new prescribing possibilities according to genetic selection criteria, there is a necessity for more specific CYP genotyping tests that could advantage and the clinical benefits of genotyping and phenotyping even before the prescribing of treatment. The pharmacogenetic tests have greater practical benefit for patients who: did not have the expected therapeutic effect with the prescribed drugs; are receiving poly-pharmacy – that is, to whom different medicines are given simultaneously; need to avoid dangerous medication interactions; will have to take long-term medical treatment with different groups of drugs (those who have chronic somatic or oncological diseases, those after organ transplantation etc.).

R.M: And the last, but not the least question. What about your own research?

E.D: This study was conducted prospectively and, for the first time in Lithuanian history, linked genetics with clinical psychiatry. Scientific cooperation between psychiatrists and geneticists was initiated, new laboratory research methods were mastered. *CYP2D6* and *CYP2C19* gene polymorphism frequencies in the Lithuanian population were performed – so far this has not been done on such a scale. After determining the predicted phenotype that could affect pharmaceutical effectiveness, the patients were recommended to change treatment. This elucidated the necessity of missing research in Lithuania – the determination of the drug concentration in the blood and improved psychiatrists' knowledge about pharmacogenetics application problems. The study showed the advantages and the clinical benefit of genotyping and phenotyping even before the administration of treatment. ■

Personalized psychopharmacology

Interview with Dag Kristen Solberg

Ola Marstein

Dag Kristen Solberg MD
Specialist in Psychiatry and Clinical Pharmacology
Head of Department
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Dag Solberg, what do you mean by «personalized medicine»?

In psychopharmacology, personalized medicine is using known biological differences to identify which treatment has a better chance to succeed. Age, gender and environmental factors, in addition to other medication used by the patient, will affect the rate by which medication is metabolized. A young, male smoker may need double dose or more of the drugs clozapine and olanzapine than an older, female, non-smoking patient. Also, genes play an important role in metabolization of drugs, CYP-enzymes are important for the rate of metabolization of around 90% of all psychopharmacological drugs, and for many of these enzymes genes decide their function. Using the knowledge of these biological and environmental factors to decide medication and dose is personalized medicine in psychiatry.

How far have we reached in the development of methods describing the interplay between person and drug?

We have knowledge of some of the biological factors that cause variation to the same drug between individuals. By taking CYP-mutations into consideration, we can explain much of this variation. Today these tests only take days to perform, which is considerably better than only a few years ago. But it is also important to note that in order for a drug to work, the physician needs to give the right diagnosis, and the patient needs to take the medicine.

The cooperation between the therapist and the patient is still the most important factor for a therapy to work, but TDM (Therapeutic Drug Monitoring) and genetic testing are tools to support the physician in making the right decisions.

Can you offer distinct "packages" of assessments today?

Yes, in addition to a broad screening of the different CYP-enzymes, our lab offers specialized examination packages for certain treatments. If a physician has decided to start with an antidepressant, we can examine genes encoding the CYP-enzymes that most commonly influence the metabolization of different antidepressants in addition to the genes encoding for the serotonin-transporter, the target of SSRIs, thus being able to suggest both medication and dose. We also have these packages for lamotrigine and antipsychotics, and also statins and analgetics, since the genes we examine not only affect psychopharmacological drugs.

Which of these assessments should come into routine use by now?

In my opinion, genetic testing should be considered before any treatment with psychopharmacological medication that is known to be affected by biological

variation, such as antidepressants and antipsychotics, genetic testing should be done before upstart. Also, TDM can be a useful supplement to clinical evaluation during therapy.

How do you imagine this can be implemented?

It is important to educate physicians about the benefit of personalized medicine. The same goes for patients, they should expect to get the best possible treatment for them, not only based on what is working best on a group level, and not on a trial and error basis. Also, it is important to ensure that the knowledge of individual factors such as CYP-genetics are available in every patients' medical file. The genes don´t change only because the patient changes therapist.

In Norway we have implemented a system whereby important genetic information can be transferred to the patients «core-journal» that is always available to the patient him-/herself and to physicians treating the patients.

Which impact could the «package courses» in psychiatry have on the introduction of new procedures in this field?

Studies show that physicians' adherence to guidelines vary, and though adequate in the initial phase of treatment may be reduced over time. Standardized examination and treatment packages will ensure that all patients get a good and professionally sound evaluation, and this will go a long way to ensure the quality of treatment for all patients.

It will also be an opportunity to highlight and ensure that personalized medicine will be offered, or at least considered, for every patient. Furthermore, it will be an opportunity to bring TDM into treatment strategies. Our studies (Jukić MM; Am Journ Psych 2018, Jukić MM; Lancet Psychiatry 2019) show that genetic testing to guide choice of treatment may lead to a lower risk of treatment failure. To recognize this and bring genetic testing into standard treatment will benefit the patients.

How is the situation in the other Nordic and Baltic countries? Do you have an established professional cooperation?

Therapeutic Drug Monitoring (TDM) is used in the other Nordic countries as well, although it is my feeling that Norwegian psychiatrists are at the forefront in understanding how TDM can guide in decision-making in personalized therapy. Our department has had extensive research cooperation with groups in the Nordic countries, especially with Karolinska Institutet in Stockholm, and at our lab we have also received samples for TDM from Iceland for many years.

How much of these topics are covered in the recommended special courses in psychopharmacology? Will today's residents be more competent than the generation that is now going out?

I think young psychiatrists today have a good understanding of the biology that leads to different patients having different effects from treatment with the same medication. Knowledge of biological factors that affect and even cause psychiatric disease has been a part of educating psychiatrists for many years, I think that the new understanding of how biological differences lead to variation in drug response is being taught to and appreciated by the psychiatrists that are educated today, and that this will be of great benefit to our patients. ■

How the doctor became a patient

Morten Saksø

Morten Saksø
Doctor at the infectious diseases department in Kristianstad, Sweden.

In our society today a lot of people are struggling with stress and exhaustion disease(ED). To fight this problem I think we need to talk about this enormous health challenge. Today the costs of stress and ED are extensive for both the individual and for the society. I would like to invite you to my own story about stress, ED and how I got through this existential crisis!

This is the title of a fantastic book written by Dr Robert Glover. In that book Dr Glover describes the "Nice Guy Syndrome". That is trying too hard to please others while neglecting one's own needs, thus causing unhappiness and resentfulness. Fortunately, he as well explains how you can stop seeking approval from others and start getting what you want in life.

That book has had a major impact on my life. I was a nice guy. I was a nice guy for 36 years until I ran out of energy. In January 2016 my body was filled up with chaos, frustrations and sorrow. At that time, I didn't have the ability to talk to other people about how I felt inside. Not even my wife, whom at that time was 2 months away from giving birth to our second child.

During the autumn of 2015 my body tried to communicate with me about the condition of my body and mind. I was tired, very tired. But at that time, I wasn't good at listening to my body signals. I had headache and palpitations on a daily basis and my memory was really poor. Going to work with these conditions was standard at that time, and I remember thinking, "If I only work a little harder, these symptoms will vanish". I was so wrong!

Even though I earlier in my working carrier, as a doctor, had diagnosed several patients with exhaustion disease (ED), I couldn't diagnose myself. It doesn´t matter whether you're a doctor, farmer or a teacher when you´re on your way to kill yourself due to prolonged stress. Then you haven´t got the ability to zoom out and get some perspective on what you are doing to yourself. People in your surrounding has to tell you repeatedly, that you have to find the brakes instead of the gas pedal.

I was good at putting up a happy face and pretending that everything was just fine. But in January 2016

my colleagues and my wife started questioning how I really felt inside. The fact that I felt awful inside, not being able to put words on or express my feelings and at the same time being confronted with questions about my mental status, was really painful to me.

During an evening at the end of January that year I decided to start talking to my wife about what was going on, on the inside of me. I cried a lot and all my feelings and frustrations just poured out of me. My wife was shocked and at the same time grateful for what came out of my mouth. Shocked because she wasn´t aware of how bad I felt inside, and grateful because her quiet husband finally started talking.

Together we wrote an email to my boss and supervisor at my job. We tried to explain how I really felt and that I couldn´t go back to work.

The next day I had a meeting with my boss and he quickly realised the serious situation and he reported me sick.

On one hand it was a huge relief to be a home, and not having to go to work. But on the other hand, it resulted in a lot of existential questions. "If I can´t be a doctor, what can I do then?". "How will this affect my role as a father and husband?".

The first couples of months on my sick leave I slept a lot. 8-10 hours every night and 3-4 hours during the day. So physically I was present in the family during these months but very often I was mentally absent. Things didn't become easier after our second child was born. As another symptom of my ED, I was very sensitive towards noise and multiple impressions at the same time. So quite often I walked around at home using hearing protection. I wasn't able to take care of our newborn child for longer periods of time, and was often, due to lack of energy, forced to hand over our newborn daughter to my wife. Every parent knows, that not being able to take care of your own child, is one of the worst nightmares. I constantly struggled with the feeling of inadequacy.

At the beginning of June, after 4 months of sick leave, I felt I was ready to go back to work (At the infectious diseases department in Kristianstad). That feeling was solely my own, I really felt I was ready for work again. That was, of course, way too early.

According to my rehabilitation plan I was at work for 2 hours Monday to Friday during the month of June. After that we had planned for 5 weeks of family holiday together. But due to my mental state at that time, I barely managed to take care of myself. The thought of being together with my family 24/7 for 5 weeks seemed quite scary, to be honest. My wife and I made the following deal: For one week I should be by myself in a rented house, and for one week our son and I would travel to Denmark to visit my parents. During the time in Denmark my parents took care of our son, while I slept most of the time.

Coming back from Denmark my wife and I celebrated her becoming a specialist in paediatrics. We celebrated by going out to a nice restaurant. During that evening we were served great food and a substantial amount of wine.

As fantastic that evening was, just as horrible was the morning after. For the only time in my life, and I never hope to experience that again, I woke up having thoughts of suicide. That was by far the most intimidating experience of my life. Fortunately, I talked to my wife about my horrible thoughts that morning. We quickly realised that I needed professional assistance quite urgently. The steps from the car, to the psychiatric emergency department, were very heavy steps. I use to call that walk "The walk of shame". Shame because of the feeling I had inside me at that time. Not being able to take care of myself and desperately in need of someone to help me. I was willing to let the psychiatrist do whatever was needed to get well again.

I met some fantastic colleagues at the psychiatrist clinic, and I got the help I needed, which I'm forever grateful for. The psychiatrist put me back on 100% sick leave again and adjusted my medication.

I was at home for the rest of 2016 and in February 2017 I started my rehabilitation at work (still at the infectious diseases department in Kristianstad) for the second time. This time it was more successful and after a rehabilitation period of 18 month, I was able to work 32 hours/week, which is the equivalent of 80% of a normal full-time job in Sweden.

As described above I started a journey of a lifetime in 2016. The journey to become a real man instead of a Niceguy. A journey that, so far, has taught me a lot about who I really am, what I want and certainly what I don't want in life. It has been a very demanding period for me and my family. I'm glad to say, that my wife and I are still together today, and we have 2 fantastic kids. As a couple we have grown together through this process, and I'm forever grateful for the support from my wife through these challenging years.

In our society today we all need to take a greater responsibility to combat the challenges of long-term stress and mental problems due to stress. From our politicians, to the employer and to every employee. I think some of the solutions are more conscious use of digital platforms, focusing on Compassion and Selfcompassion, and focusing on JOMO (joy of missing out) instead of FOMO (fear of missing out). ■

Are we missing the main thing?

Haraldur Erlendsson

ADHD is one of the most controversial subjects in modern psychiatry. Haraldur Erlendsson is a prominent psychiatrist in Iceland who has been treating adults with ADHD for a long time. His policy has been debated and discussed among doctors in Iceland. A new study on the Icelandic gene pool by Decode has discovered a very strong link between addiction and ADHD.

Attention Deficit Hyperactivity Disorder (ADHD) is a chronic condition that involves symptoms that could be categorized as physical, emotional, cognitive and spiritual. It's now well over a decade since we acknowledged ADHD in adults. However, it´s link with addiction and treatment with stimulants has had a major negative effect on the attitude of professionals and media.

The problems of ADHD seem to be on the increase, and this may partly be due to increased awareness but also due to reduced exercise, reduced routine, more isolation, less sleep and increased demands.

Current diagnostic tools have their limitations and do not always pick up areas of ADHD linked symptoms that at times cause the main problem for the individual, such as mood instability and insomnia. Prevalence is still debated with conservative estimates around 5% but is all about where to define the diagnostic level of disability. New research clearly shows that late onset is a real condition and no less debilitating than the early onset one. It may be as much as 50% of the adult prevalence. Prevalence may be as high as 15% in adulthood if all clients with some handicap are included. However, it is much higher in certain settings such as in prison and possibly also in addiction services, personality disorder services, complex trauma services and psychiatric inpatients setting. ADHD may be the most common illness of all in the population referred to psychiatrists.

The author argues that it is imperative to consider ADHD when clients have problems in multiple psychiatric domains (organic, substance misuse, psychosis, affective problems, anxiety, personality disorder, learning difficulties and development problems).

Drug induced psychosis is well known with stimulant abuse, but it is infrequently seen in clinical practice and in fact some clients with schizophrenia with chronic voices can sometimes improve on stimulants. Evidence does indicate that the two disorders may share some genetic causes. They both involve dopamine transmission in the brain.

ADHD may play a role in increasing risk of psychological trauma. There is often more risk taking behaviour, less supportive early environment and reduced ability

Haraldur Erlendsson
Consultant psychiatrist
MD, MSc, DCN, MRCPsych, Iceland

to process traumatic memories. It is the impression of those working in the field that emotional intelligence can be boosted and perhaps permanently improved with treatment while this seems to take many months or even years. Hence rushing into trauma related therapies for those with ADHD may not always be advisable and even harmful.

ADHD may be the costliest illness of mankind due to its impact on crime, addiction, accidents, completion of education and days off sick. Hence early intervention and ongoing support and treatment is essential for the individual and society at large.

While ADHD may be a major cause of morbidity and cost it is still of interest that ADHD may also play an important role in areas of high achievement such as in sports, arts, science and spirituality. When linked with high intelligence and drive it can facilitate superconcentration and high commitment leading to excellence.

Genetics assume that common genes have been selected in as they increase survival. ADHD causing genes may in the last 10 million years or longer have been selected in as they helped with hunting, group cohesiveness, tribal protection and thinking outside the box and thus aiding cognitive development and group survival.

The good news is that stimulant medications have a larger effect size than most medication used in psychiatry, however long-term compliance and finer adjustment of medication use remains a challenge.

It is time that psychiatry steps up and takes on ADHD as the leading issue in client care that can improve patients care. ■

Ketamine Treatments – Facts And Practice

Interview with Tero Taiminen

Hanna Tytärniemi

Ketamine has been used in surgical anesthesia in both humans and animals but also as a recreational drug because of its hallucinogenic and dissociative effects. There is a lot of discussion around (es)ketamine at the present although racemic ketamine has been used in the treatment of depression for years. What should we all know about ketamine? Here is an interview with Tero Taiminen who already has a long experience about ketamine treatments.

Please introduce yourself and how is your work related to ketamine?

I work in Turku University Hospital (in Finland) as a head physician in Neuropsychiatry Outpatient Clinic and Psychiatric Neuromodulation Unit. I have started the use of racemic i.v. ketamine in the treatment of depressed patients since 2010.

What are the indications for ketamine treatments? Do you think there is need for wider range of indications?

Most important psychiatric indications are treatment resistant depression, difficult bipolar depressive episodes and strong suicidal tendencies. Ketamine is studied in the treatment of addictions and anxiety disorders but these are experimental indications so far. There is no need to widen the range of indications in my opinion.

What is the effect mechanism of ketamine in treatment of depression?

There are different theories, nowadays most popular is the following: ketamine blocks GABA-ergic NMDA-receptors of interneurons and this increases the activity of AMPA-receptors and releases glutamate. This activates mTOR-pathway which in turn increases synaptic activity and plasticity of neurons.

How is ketamine treatment carried out in the clinic?

Racemic ketamine is given once or twice per week as i.v. infusion. Infusion pump releases ketamine 0,5 mg/kg/45 minutes. If patient is overweight we determine the patient's weight by calculating the ideal weight plus 50% of overweight. There is an esketamine nasal spray in the market in the USA.

For treatment safety, patients are screened with certain laboratory tests (ECG, liver functioning, urine screen and pregnancy test for women).

How about the treatment system in general?

Ketamine should be prescribed only by psychiatrists who are experienced in the subject. Often ketamine treatment is combined with the usual depression medication or other neuromodulation treatments. Ketamine also supports concurrent psychotherapy. Treatment periods with i.v. ketamine last usually from 3 to

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6 months but even several years in few patients. Ketamine treatment can be used repeatedly in relapses or as maintenance treatment. There is no limitation for the duration of treatment with esketamine nasal spray.

What kind of adverse effects are possible?

Short-term adverse effects include sensory distortions, elevation of blood pressure, slight euphoria and headache. There is a risk of suicide when treatment is finished. Long-term adverse effects have not been described in the treatment of depression. Theoretically they could include weakening of treatment effectivity, decline of cognitive functioning, increased risk for psychosis, development of drug addiction and ulceration in urinary tract.

Are there some problematic matters about implementing ketamine?

Use of i.v. ketamine requires i.v. connection and the infusion pump. Esketamine nasal spray is easier to administer but not yet available in the European Union. We have usually limited the duration of ketamine treatments up to six months.

What is the most important advantage of ketamine?

I.v. ketamine alleviates depression and suicidality faster than ECT treatment and it is nearly as effective.

Are there any „hot potatos“ in the field of ketamine treatments?

EMA (European Medicines Agency) will probably decide about the marketing authorisation of esketamine nasal spray by the end of 2019*. Esketamine nasal spray is probably not as effective as racemic i.v. ketamine. How distinct is the difference of effectivity?

(*interview was carried out in October 2019)

Is there any important message you would like to share for other psychiatrists about ketamine treatment?

I.v. ketamine should be used much more and in earlier phases of depression than it is used at the present. Prolongation of depression increases the risk of chronic illness even in the course of months.

Personalized care for patients with ADHD

Interview with Tamara Kuntelija-Plieskė

Ramunė Mazaliauskienė

ADHD is a diagnosis that affects many people - from children and adolescent to adults. All of them have to deal with challenges caused by their disorder. How can the mental health system help them? What are the treatment options to be provided? What treatment options are - if they are- the best? Tamara Kuntelija- Plieskė, the head of private mental health institution that provides diagnostics and help to people who suffer ADHD, will try to answer those questions in the interview.

R. M: Let's start with a general overview of ADHD services: is care for ADHD patients well established in Lithuania?

T. K-P: Attention deficit hyperactivity disorder was quite widely known and treated in child and adolescent psychiatry, yet the adult ADHD patients until recently had no opportunity to be diagnosed. Approximately 1 out of 25 adults has the ADHD, and around 90% of them remain undiagnosed and consequently they cannot benefit from available treatment options.

R. M: What are the main challenges that patients with ADHD face on a daily basis?

T. K-P: Mostly these are the problems with executive functioning. In plain language this means inability to focus or to maintain the focus and deliver results, poor management skills, forgetfulness, impatience and impulsivity. Giving the high rates of under-treatment, people with ADHD continue to suffer from underperformance, low achievements, at times chaotic or disorganized lifestyle, personal and social problems resulting in low self-esteem, mood and anxiety disorders. Therefore, when we discuss the choice of the treatment options, we must consider all the interventions (pharmacological and non -pharmacological) to address the need of the individual patient.

R. M: Psychopharmacology treatment for ADHD is evidently efficient. Is there evidence for effectiveness of non-pharmacological treatment options such as psychotherapy?

T. K-P: Medication treatment should always be considered, but we must remember that nearly 50% of adults either cannot take medications or do not respond, or even on treatment have residual symptoms. Also, if medications is the standalone solution, we need to keep in mind they work for limited amount of hours a day and after the effect wears off, the symptoms return. Therefore, we need to strike delicate balance here that the needs of the individual patient are addressed.

According to NICE guidelines, CBT should be considered when patient has made a choice not to have pharmacological treatment, or when medication treatment has proved to be only partially effective, or when psychological treatment is considered sufficient to target residual functional impairment.

How it works? CBT aims to change patient's behaviour and the thoughts that reinforce the negative and harmful effects of ADHD. It also provides the patient with the techniques to control the symptoms, improve self-esteem and help to cope with negative emotions, such as anxiety and depression..

There is a solid body of evidence for Cognitive behavioural therapy-oriented approaches in ADHD. Reportedly CBT significantly reduce the symptoms and the functional impairment in ADHD patients.

At our ADHD service we provide both individual and group therapy models containing 13 modules, that include: psychoeducation on ADHD neurobiology, techniques to stay concentrated, chaos and control: time management, day and environmental structure; management of emotions, management of behaviour, impulsivity management; stress reducing techniques, work life balance, addictions, relationship problems. Although we have clear structured therapy, we also tailor it according to specific patient's needs. So, if the

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Consultant psychiatrist, Founder of Adult ADHD Center in Lithuania.
Former NHS UK Consultant in General Psychiatry

patient has comorbid social anxiety disorder or dual diagnosis with addiction disorders, these comorbidities are effectively addressed as well.

R. M: And what about meditation? Can it be of any help for ADHD patients?

T. K-P: Due to small numbers of studies, Cochraine meta-analysis was inconclusive whether the Meditation therapy is effective, but it was regarded as having no adverse side effects on patients. Our specialists in Mindfulness therapy notice that patients face the difficulties to maintain focus during meditation practice and sustain this practice at home. Moreover, very few of them do the assigned homework. Yet some of our patients report that having meditation and cold showers in the morning give them better attention focus for up to 2 hours.

R. M: How important for the course of ADHD is the lifestyle choices? Can ADHD symptoms improve provided lifestyle remains unchanged?

T. K-P: You touched a crucial question in managing ADHD. Lifestyle choices are fundamental if we want to have positive long-term outlook of this disease. We can even see this with pharmacological treatment, the effectiveness of which is highly impacted if the person consumes a lot of junk food with food preserves and colorants or if there is a high intake of food with high glycaemic index. Again, physical activities show great benefits on ADHD symptoms.

R. M: Is there any specific sport activity that can be beneficial for ADHD patients? And generally, how can physical activities change the way ADHD patients perform?

T. K-P: Physical activity not only enhance coordination and is a good way to get rid of excessive energy exhibited by ADHD patients, it also gives a structure and better organisation. Team sports, for example, help to improve the social skills and planning ability and decreases impulsivity. It is important to note ADHD is not only a burden, it is also an opportunity to uncover and expose talents, especially in sports. Due to hyper-focus phenomenon and ability to show maximum focus on activities people with ADHD are interested in, they can achieve extremely high results in sports. Just think of legendary US swimmer Michael Phelps!

R. M: You mentioned dietary impact on manifestations of ADHD symptoms. Is there any evidence for ADHD specific diet? How much does your patients follow dietary advice from you?

T. K-P: Almost 50 years ago scientists raised the hypothesis on the effect of food colorants, synthetic dyes and preservatives on the brain affected by ADHD. Until today there is no solid evidence of the direct impact these agents have on ADHD brain performance. However, after publication of the results from one well designed RCT trial in Britain, British Food Standards Agency urged food manufactures to eliminate 6 artificial colouring agents from food marketed and sold to children. And although no dietary recommendations are included in current ADHD guidelines, supplementation with omega-3 fatty acids is effective in ADHD treatment (category 5 evidence), as well as elimination diet, which has category 4 evidence – as probably effective.

R. M: What elimination diet do you offer to your patients?

T. K-P: We have a dietologist in our team who thoroughly examines the patients and their nutritional diaries, so all recommendations are given in a personalized way. Most often patients are offered to restrict or avoid taking food or ingredients that might trigger certain unwanted behaviour/hyperactivity or worsen inattentiveness. Usually patients notice that sugar restriction enhances their performance and diminish "brain fog".

Then patients are also advised to consider some food supplements, such as omega -3 fatty acids. Recent study showed the efficacy of omega -3 supplementation when EPA was taken in doses around 2 g/day. Some patients find favourable effect of adding zinc, magnesium, folic acid and Vitamin B group to their diet. Again, one should be warned that high doses of vitamins can be toxic. So, the best way to manage ADHD symptoms includes medication and non-medication treatment together with balanced healthy diet.

R. M: And the last question: what is your opinion on neurofeedback therapy in ADHD?

T. K-P: Neurofeedback is the method when through the monitoring EEG brain waves activity patients get feedback when brain works at optimal (or desired) level. This feedback helps patients to learn how to sustain that level of functioning. Usually it takes around 30 to 40 sessions (1-2 per week) of neurofeedback to deliver sound results in terms of the patient's ability to concentrate. We apply neurofeedback in our service only as adjunctive therapy firstly to our younger patients. One of the most recent meta-analyses published this year in the journal of European child & adolescent psychiatry concluded that neurofeedback can be considered a non-pharmacological treatment option for ADHD with evidence of treatment effects that are sustained when treatment is completed and withdrawn. At the same time authors of this meta-analysis indicated the need for further research on the comparison of standardized neurofeedback treatments with standardized control treatments. In our clinical practice we consider neurofeedback as effective treatment if it is paired with psychostimulants treatment, but not as a standalone treatment option. ■

Recertification – a process has started in Norway

Ola Marstein

Alongside all current external processes affecting medical specialization in general and the streamlining of psychiatry in particular, a movement from inside our own ranks has started.

The president of the Norwegian Psychiatric Association (NPA), professor Ulrik Malt, has educated doctors in Scandinavia and on the continent for many decades. He agreed to take this post because he had a brave ambition: raising the competence of psychiatrists. This goes for biological aspects and psychopharmacology as well as for psychotherapy.

Now he is in his second and last term as president, and with the support of the board, a working group has been established. All sections of the NPA are represented in the working group. The goal is to present a report to the Norwegian Medical Association (NMA) by the summer of 2020.

Among Norwegian physicians, only the general practitioners currently have a mandatory recertification, demanding participation in a colleague supervisory group and attending a number of courses every fifth year. For psychologists a similar specification has been set up. The NMA is since 2016 working (slowly) towards mandatory Continuous Medical Education consisting of a combination of mandatory visits to other institutions or departments, international and national congresses and professional courses, with a voluntary part consisting of also research, quality work, e-learning etc. However, none of these recertification systems require that the participants must pass examinations or tests in order to be recertified.

The working group has looked both to Europe and to the United States to find good models. In Europe, only Ireland and Switzerland have something similar to a genuine recertification procedure, as was reported at the recent UEMS meeting. The EU is planning to make recertification an option on a European level, but only as an additional qualification to the eventual national regulations. As far as the group knows, there are no such processes going on in the other Nordic or Baltic countries. In the US, the American Board of Psychiatry and Neurology, Inc, is the body authorized to recertification, although the status of this process varies from state to state. However, the exams are quite formalized, with strict supervision of the candidate when they tackle tasks based on clinical vignettes and answer more theoretical questions.

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Practising psychiatrist, Special advisor

Ulrik Malt, himself an experienced textbook editor, finds the exams quite difficult, and so did the members of the working group. Although they have sympathy for the strict American program, the group is working towards a more modest model, based upon the NMA principles from 2016, as mentioned above, but with some amendments. When attending a course, there should always be an exam – and this must be passed! Participation and good intentions will not be sufficient for recertification. Every section in the NPA should prepare courses with such exams and e-courses too. These can be built upon existing e-courses from the UEMS, WPA and the American Board. An alternative is to wait for an all-European model from the UEMS.

This recertification system should be made mandatory for all psychiatrists. The obligations to deliver high quality clinical care will become stronger in the near future, and psychiatrists will be dealing with the most severely ill persons, who suffer from both mental and somatic disorders simultaneously. Without the skills needed, psychiatrists will run the risk of being even more marginalized than we are in today's Norwegian mental health care.

The Nordic Psychiatrist will come back with the final report from the working group in the course of 2020. ■

Psychiatry needs EFPT and vice versa, but how?*

– a SWOT analysis.

Andreas Hoff

The article is a personal account of his experiences with EFPT

*Warning: may contain traces of irony.

This Summer, I ran for President of the European Federation of Psychiatric Trainees, EFPT. After eight years of consecutive participating in its Annual Forum and chairing the Bylaws Committee in four (obviously the most important, and not-boring entity in ANY organization), I considered the election a walk in the park: how could EFPT not unanimously elect such a richness of experience as Their Leader? I thought delegates would exalt my straightforward vision about fixing the many financial issues, which had recently been reported to the General Assembly by the Controlling Committee: change was needed, and I was the only candidate with that in my agenda.

But I lost. And that gravely. No candidate got less than my five votes. The winner: 17.
I like to think the delegates were not ready for my progressive vision of more transparency and less industrial conflicts of interest. The reason, though, was more likely my diplomacy-depleted personality, and perhaps the fact that I only chose to run after 8 years, very close to ending my training, despite EFPT being for trainees! Contrary to the other young candidates I was probably perceived as many sadly perceive US president candidate Bernie Sanders (just without the charisma, altruism and self-sacrifice), whom they sadly think is too old and ill. I am though *not bitter AT ALL* and the reader doesn't have to bear in mind anything but the fact that I am–still–very impartial. After all, since October 11 this year, after years of training, I am finally a psychiatrist – a representative of objectivity itself.

Andreas Hoff MD
Andreas Hoff is a specialist in psychiatry and a comedian (known for entertaining at the NCP banquet).

During the moments after my excruciating defeat, the recent Forum-naïve winner pitifully announced hope that I would "share my wisdom and EFPT experience" with her. I'll do that in the following, conducting a SWOT analysis (obviously that's what she implicitly asked for), developed personally through my time in the EFPT working group I started in 2018, called "Structural Alterations and New Economy [SANE]".

Of many strengths, the most important are the continuous cultivation of networking opportunities. Through these, trainees acquire insights and perspectives on mental health care and training across borders. This is of huge value to national professional networks to be inspired by other trainees. Indispensably, EFPT holds essential positions in major regulatory bodies, defending trainees' interests.

The greatest weakness is a poor financial and organizational structure, in part due to great differences between member countries' economic levels, entailing dependencies of other parties. This inflicts the much-needed integrity, in a field of many competing interests and, very regrettably, sponsorships are far from transparently reported.

The major opportunities are to empower national training associations to steadfastly ensure high quality training, regarding competencies as well as work environment, sadly still very varying between countries and some member organizations highly need support to gain momentum. If the federation achieves such impact consistently, members would be even further motivated to pay higher fees, solving the financial trouble.

In conclusion; to truly achieve its vision, EFPT should maintain important current activities like e.g. annual fora, including the brilliant parties with much dancing and a visionary flood of alcohol, and the unique Exchange Programme, sending trainees across borders, experiencing foreign psychiatric models. But it is imperative that finances become more stable, and that organizational structure be matured into a more transparent, regulated, and consistent one. Otherwise EFPT will remain a place for the few lucky ones who discover how lovely its members are – I did, which I am uttermost thankful for. I wish all trainees similar experiences and I strongly encourage all Nordic psychiatric associations to consistently support EFPT many years forward. ■

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Psychiatric residency training in Sweden:

The METIS initiative

Peter Lönnqvist

In 2008 a new regulation defining the required competence for a Swedish Psychiatrist was established. The new definition put forth a mandatory increased theoretical learning content in the five-year psychiatric residency programme.

A large hurdle in this was the fact that there quite simply didn't exist courses enough to match these new demands.

As this was well known beforehand a project already had been initiated in 2007 from the Swedish Psychiatric Association with the aim to develop theoretical courses adapted to the new requirements. The project was given the name METIS for MEr Teori I St-utbildningen (More Theory in Residency Training), but also, as it happened, Metis being a Titaness from Greek mythology - the mother of wisdom and deep thought!

There already existed funds allocated by the Swedish government in The Ministry of Health and Social Affairs for development and improvement of the country's psychiatric care on all levels, and a grant of an initial 18 million SEK was given to the METIS-project. In the later stages of the project another 17,7 million SEK were granted.

Principal for the project was the Swedish National Board of Health and Welfare (Socialstyrelsen) and the executive responsibility was given to The Physicians' Institute for the Professional Development of Healthcare (IPULS, now LIPUS).

Initially the project, inter alia, investigated education at The Royal College of Psychiatrists in England in order to find models for developing a modern form for Psychiatry education. Evidence based educational methods were investigated and the project also, from an early stage, incorporated medical education researchers and specialists from Karolinska Institutet in Stockholm.

A curriculum was designed with the aim to create a smorgasbord of courses that the resident could choose from depending on personal or other preferences, but also, with a wise combination of courses, would fulfil the goals in the new regulation for Psychiatrists. Courses were designed to match where the resident currently is in the programme, i. e. courses like Psychiatric Diagnostics, Psychiatric law, Acute Psychiatry are to be taken early; specific disease-oriented courses such as Affective Diseases, Anxiety Diseases, Psychotic States to be taken in the middle, and in-depth courses like Psychiatry and Society, Eating Disorders, Sexology, Forensic Psychiatry, late.

Courses were designed in order to incorporate blended learning, where parts of the course are fulfilled online and parts in the classroom. The courses are designed to require the participants' active study before the physical course meeting (assessed by several tasks such as quizzes and written assignments), active participation at the meeting, and a final written assignment concluding the course. All in all, a typical course runs over a month with a start online where the participants are given access to the course material and tasked with the abovementioned assignments, a three day physical meeting with lectures and exercises, and a concluding assessment phase, including teachers' feedback, online. In total a course requires 40 hours of participants' work. The recommendation is to spend 12 hours for subject studies before the course meeting and four hours of assessment work after the meeting.

Peter Lönnqvist
Pedagogical developer
Uppsala-Örebro Regional Metis Office

The course meeting is 24 hours over three days in succession.

After a few trials and evaluations of courses the main course development work started in 2008. In all a total of 22 subject courses were developed over a period of four years. Involved in the course development work were medical education specialists (including online education), university researchers from the subject area, active clinicians, residents, and patients.

As courses were finished in development they were rolled out, usually with the (somewhat surprised!) clinicians as responsible for the course and as teachers. The course development work did not use up all the funding, which also was part of the project plan, so it was possible to give the courses in each subject, at least twice, free of charge. This helped each course subject to gain momentum.

As METIS, in its government-funded project form, ended in 2012, 22 new course subjects had been developed and deployed. More than 90 new courses had been given with a total participation of over 3000 entrants (several residents attending multiple courses). During the period the project was tasked by the government with developing courses, using the same successful method and design, for Child- and Adolescent Psychiatry. That sub-project ended in 2015 having developed and deployed 16 subject courses.

More than 200 professionals have been involved in the development of the courses; many of them becoming recurring course teachers.

After the government-funded phase the project has become a semi-permanent national organization with the county councils as principals. There now exists a METIS office in each of the country's six different healthcare regions. Each office is responsible for its regions courses and the whole network meets about once per semester in order to divide and decide courses between the regions in order to give enough, and not over establish, courses in the country. The regions' METIS offices care for all the logistics around the course; from participants signing up, the online parts (in cooperation with the teachers), reminding participants when tasks are due, course diplomas, billing etc.

One of the regional offices also acts as a Central Office with responsibility for the online learning platform, keeping a course catalogue, recurring revisions of all course subjects for the entire country, developing new courses, the first stage of participants course applications, hosting the METIS networks meetings etc.

In 2018, 58 METIS-courses in Psychiatry were given with 1558 participants. Five courses in Child- and adolescent Psychiatry were given with 124 participants.

Several courses for full-fledged Psychiatrists have also been developed and deployed using the METIS-format. The demand among the specialists has arisen as further learning for has been sadly neglected in the country and Psychiatry is a rapidly developing and changing subject. Using the METIS format for education and the support structure from the METIS offices makes it possible to organize new courses. ■

METIS
- a successful course concept

Karolina Sörman, Denada Aiff,
Lise-Lotte Risö Bergerlind

Metis courses for residents in psychiatry is a well-known concept in Sweden. The development has gone from a shortage of courses offered in a few different geographical locations, to a rich panoply of courses offered across the six regional offices within the Metis network. What success factors have paved the way for this development? We look back at Metis history, describe the pedagogical model and gaze into a near future.

Metis ("more theory for residents") is a course concept for education of residents in psychiatry, using a unique method. The Metis project aims to create a coherent education in order to increase the number of specialists in psychiatry. This could contribute to homogeneous health care delivered across the country, assuring high quality for patients in psychiatry. The Metis pedagogical model, which uses "constructive alignment" where learning outcomes and assessments are closely aligned with the teaching programmes, raises the likelihood for learning and improvement of practical clinical skills.

The origin and development of the Metis concept

Metis courses were developed in close collaboration between clinically active chief psychiatrists, researchers within the respective field, resident physicians and user representatives. This method assures that the courses meet the required level of evidence, clinical relevance and ethical standards. All courses undergo regular revisions, coordinated by the central office. The development has gone from a shortage of courses offered in a few geographical locations, to a rich panoply of courses offered across the six regional offices within Metis network.

Pedagogical model

Each Metis course encompasses three subsequent phases. During the first phase, the resident physician works with the selected literature and turns in a first individual assignment. The aim of this phase is to provide the participant with an improved understanding of the topic and to be well prepared for the subsequent phase.

The second phase consists of a course meeting during three days. Participants then meet clinically active psychiatrists, researchers and patient representatives. Participants work with different activities such as interactive lessons and group assignments, bolstering their theoretical knowledge and clinical skills. The last phase goes on during eight weeks. During this time, the participant is using the novel knowledge in a practical, clinical setting - assessed through a written examination task. This setup encourages novel knowledge to be integrated into clinical practice.

Where is the Metis concept heading?

In Sweden, education for intern physicians and residents in psychiatry is characterized by clear regulations. Specialist training in psychiatry, however, is completely unregulated. This is notable, since this phase is the longest period during a psychiatrist's working life. Sweden is one of few countries in Europe that does not have any formal requirements for specialist training in psychiatry. At the same time, psychiatrists are increasingly expected to be updated on new treatment methods. Throughout recent years, specialist training in psychiatry has decreased to about six days/year. This risks leading to a situation where psychiatrists are not well updated on novel treatment method and research, and in the long run it could have a negative impact on working environment and the health care delivered.

Based on the lack of educational structure for specialist training, we have started developing such courses following the Metis-concept and pedagogical model. Within this new track, both basic and advanced cours-

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Karolina Sörman

es are designed, where participants are provided with an update on novel research and treatment methods. Together with psychiatrists, managers and researchers, we are currently mapping the need for specialist education. Based on this, tailored courses will be designed to meet identified needs. At present, nine courses for specialists have been created. To improve the competency of specialist psychiatrists across the country, it is our belief that the content and structure of continuing education should be regulated on a national level. The specialist's competency portofolio should also be evaluated at career development talks.

At present, there are three lines of development within the Metis network: *(i)* development of Metis-courses for specialists in psychiatry; *(ii)* Metis-courses for nurses in psychiatry, and *(iii)* continuing education for cross-disciplinary groups of staff within psychiatry.

The second line of development is our Metis-courses for nurses within psychiatry. In the Gothenburg area, two pilot courses have been conduced and a third one is being designed at present. These courses cover psychopharmacology, suicide prevention and ADHD. An expert panel of nurses within psychiatry, with academic background have had an active role in the course development. The first two courses were well received by nurses and their managers. The pilot courses will be further evaluated through in-depth interviews assessing content, structure and relevant outcomes.

A third extension of the Metis concept is planning of continuing education for cross-disciplinary groups of staff within psychiatry. There are areas such as knowledge in psychiatric diagnostics where it would be possible to educate psychiatrists and psychologists in parallel. This could lead to a common view on patient problems, and strengthen cross-disciplinary collaborations. It could also lead to synergistic effects and improved health care quality. We need to develop both educations targeted for specific staff within psychiatry, but also for mixed groups of staff in order to meet the high demands in modern health care. ■

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Swedish chairman, with a passion for education - and risotto!

Interview with Alessandra Hedlund

Hans-Peter Mofors

In March this year, Alessandra Hedlund was elected as the new chairman of the Swedish Psychiatric Association. Since then she has been even more busy than normal, and after some time of emailing, we were finally able to find an opening in her calendar, a late Friday afternoon.

Alessandra receives me in her office at the S:t Görans Hospital in Stockholm, a beautiful building, built more than a hundred years ago and located on a height with gorgeous views over the city.

When talking to Alessandra, the first thing that one notices is how excellently she uses the Swedish language, although she came to Sweden from Italy as a young doctor just fifteen years ago.

How come you speak such flawless Swedish, Alessandra?

Hard work and good teachers, nothing else. It took time and effort but there are no shortcuts. It felt very important since language is our main tool in psychiatry. I enjoy reading which has been a great help. Eventually I found Swedish to be a beautiful language.

It was the educational situation in Italy that gave her inspiration to seek a resident position in another part of Europe. If she had stayed in Rome to get a specialty training position, she would have had to wait for years in order to get in to the educational program.

So, after her psychiatry residency in Karolinska Hospital in Stockholm, Alessandra focused on work with neurodevelopmental disorders, a field she has stayed with ever since. – I enjoy working with the whole spectrum of developmental disorders. It is challenging – no case is similar to the other. Working with these patients means a lot of educational efforts, in order to get compliance and help them better deal with their daily life.

And the very question of education is an integral part of Alessandra's working life. For years she has worked with various forms of education, from medical students to postgraduate and interprofessional education. As part of METIS' project group (see another article in this issue) she has played a major role in changing the theoretical part of psychiatric residency in Sweden, involving the students in a more active way. Since three years, she works as postgraduate program director for trainees and psychiatry residents at Norra Stockholms Psykiatri, S:t Görans sjukhus.

-I believe that one of the major pitfalls is the belief that you have to teach every detail of the subject, both theoretically and practically. With such an aspiration, the students will not grasp the broader picture. "The greatest enemy of understanding is coverage, according to Howard Gardner at Harvard University", she says. However, the education has moved forwards a lot the recent years, she says. Today there is more focus on reflection and discussion.

You have been associated with the Swedish Psychiatric Association for many years. Tell me about this.

-Yes, it has been a great joy. I began working with the committee dealing with educational issues. The work within an association is very rewarding and gives you lots of perspectives that you otherwise would not get. It is interesting to get a deeper understanding about the process behind the various decisions made. And there is also a possibility to influence the outcomes.

What are the main tasks of the Swedish Psychiatric Association?

-It is to gather psychiatrists in our country and work together to develop the field. For us on the board I find it extremely important to remember that we represent all psychiatrists, not only scientists, hospital doctors

Alessandra Hedlund
President of the
Swedish Psychiatric Association

etc. We need to prioritize questions that are important to the majority of our members. There are different ways to interact with the members; I believe that our annual congress is one such arena, but even our journal and the congress travels we arrange.

You mention the congress. It has become such a success. Why is that?

- That is true. The numbers have risen tenfold in ten years from around 60 participants to more than 800. I think there are many contributing factors: a better and broader program for one. We engage many of our members in creating the program. I also think that a good national conference is a more convenient and better alternative compared to international meetings, which are much more expensive too. Hence I believe that employers too appreciate our congress.

You mention the journal, which is still published in a printed form. Why not only online?

- Our journal is very appreciated and read by most members. I believe that both young and older readers like to keep and read something you can hold, put aside and then come back to. The journal is a good medium for communication about psychiatry and is just getting better and better. We publish it together with the associations for child and forensic psychiatry, which increases interest and understanding for neighbor fields.

What should psychiatry focus on in the years to come?

- There are many important things. We need to ensure that the competence level among specialists is maintained. How this should be done is a tricky question. It seems that people today are more prone to seek for mental problems, stress or malaise. However, all of this can't be dealt with by psychiatrists. The question of what is to be treated by psychiatrists needs to be better defined, both to ourselves and to the general population. Another question that interests me is the role of early intervention. It is known to be useful in psychotic disorders. But is it important to all kind of mental suffering? Symptoms of different disorders can occur at the same time in adolescents or young adults and it can take many years until the disorders' main characters show. This means we may have a window of opportunity for interventions that doesn't necessarily target a specific diagnosis.

What are your experiences after half a year of being chairman?

-Oh, it is very nice. In the beginning I was a bit concerned how it would turn out. But I have many nice and competent people around me on the board. Leadership can be performed in many ways. Most important, I believe, is to be true to yourself and not try to imitate others who have held the post before you.

Finally, Alessandra. I know that cooking is a passion of yours. You mentioned that the Italian risotto has a special place in your heart. What constitutes a good risotto, and how is it best made?

Risotto is my signature dish! My mother was born in Milano and she has always been very proud of it. Italian food culture is very local, I was born and grew up in Rome where most people like risotto but don't know how to cook it. The recipe is actually easy: fry the chopped onion in olive oil, then the rice, add the wine and afterwards, little by little, the broth. When it's ready, stir in the Parmesan cheese and serve right away – that's it. My mother says butter is the key ingredient but to me, patience is key! Risotto can't wait so you have to wait for it. It's tricky to figure out how long each step should be, so I recommend you practicing on a base recipe, like saffron risotto. Once you get the basics right, you will be able to experiment with your risotto as much as you want. ■

The EPIC Health Platform challenge in Denmark

Hans Henrik Ockelmann

The introduction of the EPIC system in some Danish regions has had a number of negative consequences for patient care

It's hard to imagine a modern hospital in the Western hemisphere being run without extensive use of computer technology. The switch from typing records directly on paper and filing it by hand has taken place during the last 20 years.

The first computer systems seemed clumsy and unfinished to say the least. They were made up of bits and pieces, they only barely succeeded in doing the job and was by no means integrated with each other.

In Denmark the need for a more modern and "whole" approach to the systems resulted in rather smooth integrated solutions. But considering that Denmark is a pretty small country with less than six million inhabitants it is remarkable that we ended up with two rather different solutions: In the Western part of Denmark the choice fell on a Danish developed system known for its simplicity and user friendliness but in the Eastern part, we wanted a futureproof all-singing-all-dancing system, that should be able to integrate all conceivable functions, support time-true registration, standardise documentation and make it easy to extract and manipulate all the wealth of information within the systems to all hearts' content.

From May 2017 this EPIC based EHR (Electronic Health Record) system called "Sundhedsplatformen" (the health-platform) was implemented in psychiatry – first in The Capital Region and a little later in The Region of Sealand. Before introduction, we were promised, that although we as doctors now should type the records by hand without assistance, the improvements in quality of records and streamlined workflows would more than outweigh the obstacles, the system could cause.

Not very surprising reality showed something different. And that has to do with the backbone structure of the system: Quick registration of health procedures, so you immediately can charge the patient and insurance company. This demands an extensive level of automation and standardization of the registration.

This is a very important function in for instance the US, but in many European countries including Denmark, the health system is public and general, and when this function is not paramount the system's shortcomings become very obvious: The documentation is reduced and simplified with the use of large amounts of tick-boxes, and automatic text generation.

Hans Henrik Ockelmann
Senior consultant of forensic psychiatry,
board member of The Danish Psychiatric Society

But the idea that every aspect of a patient contact can be fully standardized is of course a false one. Most patients in psychiatry as well as other specialties have much more than one health problem, that have to be addressed at the same time. This complexity demands specialized knowledge and thorough documentation that our EHR isn't suited for. And the time for the documentation, the doctor has to type in by hand naturally reduces the time for patient contact.

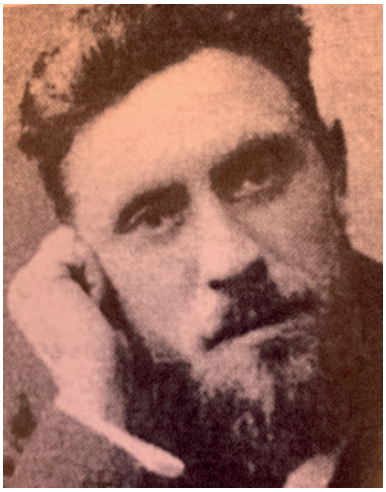
I find this aspect to be the most harmful for the efforts to retain and develop the quality for psychiatric service in Eastern Denmark, but the Danish implementation of EPIC EHR has had other very alarming results, as recently pointed out by the chairperson of The Danish Psychiatric Society:

- Grave reduction in the quality for documentation and communication.
- If more than one health professional is involved in the care and treatment of a patient, they cannot document their work at the same time. This could lead to vital information not being available for the other professionals involved.
- Increased risk of medication errors due to an erratic medication module, that has been sought fixed -in vain - since the introduction of the system. Even today there are risks of patients getting for instance double doses of antipsychotic depot medication.
- The system is very huge, messy in presentation and layout, procedures are longwinded and counterintuitive leading to serious risks for patients, that may not get the right procedures or prescriptions.
- Maybe because the system focuses on billing procedures, the fragmentation in the medical records makes it close to impossible at a later time to create a full picture of the totally essential process of examination, diagnostics and treatment of slightly more complicated cases. ■

Thordur Sveinsson

Icelandic pioneer in psychiatry

Óttar Gudmundsson



Thordur Sveinsson

Óttar Gudmundsson wrote the history of Icelandic psychiatry in 2006. He studied the life of the first psychiatrist in Iceland Thordur Sveinsson and how he influenced the mental health system in Iceland. Ottar writes about Thordur in this short review.

Near the end of the 19th century, Icelandic medical doctors and officials started writing to the ministries in Copenhagen, raising concerns over the situation and treatment of people with mental illnesses. Iceland was a Danish colony at this time. The first hospitals for mentally ill persons in Denmark were established at the beginning of the century, which was also the case elsewhere in Western Europe. Iceland, however, was on the losing end in this regard because of its isolation, the small population and the primitive living conditions. The medical doctors described the often tragic situations and inhuman treatment of the mentally ill, and demanded improvements. The officials in Copenhagen dragged their feet in these matters, however, demanding all kinds of information before improving the circumstances of these ill people could be made. There was correspondence between these two countries but, yet, nothing came out of it.

Despite such attitudes, things started moving early in the 20th century when a decision was eventually made to build a mental hospital for 50 patients at the outskirts of Reykjavík. The hospital's first physician was Thórdur Sveinsson, who was encouraged to prepare for this work by going abroad for clinical psychiatry education. He went first to Denmark, then moved on to Germany where he studied for some time under the guidance of Emil Kraepelin in Munich, who was at the forefront of psychiatric medicine at this time.

Upon his return in Iceland, Thórdur assumed the position of chief surgeon of the Kleppur Psychiatric Hospital as it was named then. The hospital immediately filled to capacity and it soon became apparent that it was way too small. During these years not many options were available to people in need of psychiatric treatment. All institutions for the mentally ill in Europe were overfilled and many people spent several years there.

Relaxants, for example, barbiturates, bromide and chloral, had materialized and were used to calm and quieten mentally ill people. The national authorities regarded these hospitals as storage venues for individuals who found it hard to adjust to society for various reasons. Much violence went on at these institutions. The patients were placed in straitjackets and other restraints, and usually there were solitary cells at these institutions for the most hard-to-handle patients.

Thórdur was the only psychiatrist in Iceland during the next 20 years and in many ways he was quite an unusual physician in his field. He strongly emphasized that the patients should work as a part of their treatment. Most of the patients were farming people and Thórdur operated a large dairy farm at the Kleppur hospital with cows and horses. The patients cared for the livestock as well as carrying out various work with sheep wool, just as they were used to doing at home.

He was not keen about medication, in fact he rarely administered it. He used solitary confinement and various straps and ropes like his colleagues, however, on a smaller scale.

Thórdur was a strong believer in hydro-therapy, i.e. using hot and cold baths, and potable water for the patients to drink to address their psychiatric ailments. This entailed the patient only consuming water, 55 C° warm, for a few days or even weeks. This treatment was criticized by many; however, Thórdur was firm in his approach and strongly defended his water consumption therapy. Some people maintained that this was in fact a starvation treatment. Thórdur held meetings in Reykjavík to discuss his hydrotherapy and wrote books in its defense. His opinion was that the drinking-water therapy was a particularly effective way to distract a patient from his mental illness and to direct his mindset to other and healthier paths. He did, however, use this method of drinking-water treatment on other patients. When the Spanish epidemic hit Iceland in November 1918, a small hospital was established at a school in Reykjavík. Thórdur was appointed as chief surgeon and treated his influenza patients with his warm drinking-water method. Other physicians protested and Thórdur was criticized for this treatment. Apparently, there was more criticism about this treatment being used on influenza patients than on mental patients at the mental hospital.

Thórdur was particularly influential in the Icelandic community at this time, as he was involved in politics, wrote poetry and taught medicine and classic languages. When the Kleppur mental hospital was enlarged,

Kleppur hospital recently built in 1908.
A nursing student poses in the foreground.

a new psychiatrist, Helgi Tómasson, came back to Iceland from Denmark. He did not want to work under the supervision of Thórdur; hence the hospital was divided into the old and new hospitals, each with a separate chief surgeon.

It is interesting to note when examining Thórdur's history, that clearly his methods were indeed different from many of those practiced in Europe. His water-drinking method became well known among the Icelanders, whereas it was not practiced in this manner or extent elsewhere. Surely one cannot but wonder whether these treatments yielded worse or better results than the methods used elsewhere. My response is to maintain that Thórdur was a pioneer who was not afraid to explore new paths in times that were characterized by surrender and lack of action in the treatment of mental patients. ■

Hydrotherapy with hot and cold baths

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Herman Wedel Major

The father of Norwegian psychiatry

Ola Marstein

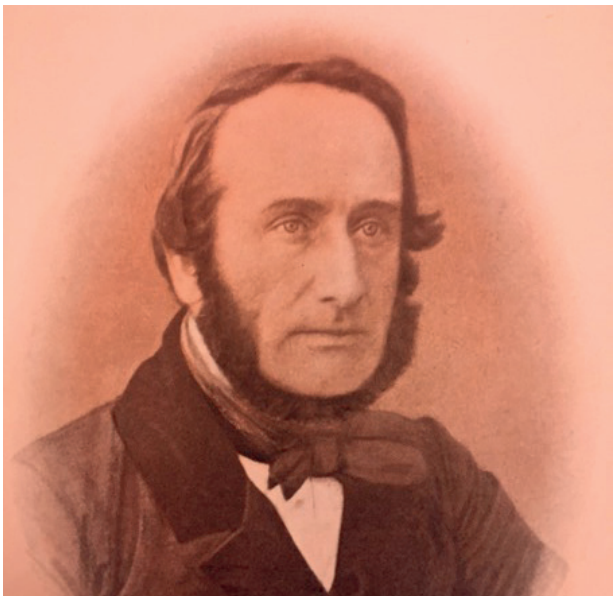
A young man, the son of a rebellion immigrant, established modern psychiatry with a new-built institution and a modern law in the course of a few years after medical graduation

Although the Norse sagas mention Viking kings who obviously suffer from both depression and delusions, no system for the treatment or care for mental disorders in any way was established before the middle of the 18th century. At this time certain "hospitals" (meaning houses of care for elderly and poor) were instructed to reserve one or two rooms for persons deemed to be insane or furious.

Enter the young physician **Herman Wedel Major!** He was born in 1814, the son of an Irish revolutionary who had fled to Norway, and became a well-to-do industrialist in Kristiansand in southern Norway. However, he got depressed in late life, and took his own life when his son Herman was 25 years old.

Herman studied medicine, but when his fiancée Fanny Rahbek had recurrent agitated depressions, there was no place in Norway where he could find medical help for her. By 1842 he had finished his medical studies, and went with Fanny to dr Peter Jessen in Kiel in Slesvig, then part of Denmark. Major stayed to learn the new principles for the treatment of mental disorders, and even made a tour to Germany and France to study the work of pioneers Philippe Pinel and Jean-Étienne Esquirol. Up to their time, "the furious" were looked upon as incurable, and had to be locked up, away from others, even together with animals. Jessen had been inspired by these pioneers to regard persons with mental disorders as mentally ill, who could be cured! He gave them voluntary treatment in medical institutions.

Major returned to Norway in 1844, and wrote a complete plan for a **state-owned asylum** together with his brother-in-law, the architect Heinrich Schirmer who also undertook the construction of a central prison and the railway station in Oslo, both prestige projects for the young Norwegian state. The Parliament granted money for the asylum to be built on the property of a farm, which he considered a health-bringing surrounding for struggling persons. and the work started in 1845.



Herman Wedel Major (1814-1854)

After ten years, Gaustad Asylum was ready for use, situated in the outskirts of the capital Christiania (today's Oslo). The contact with the University, established in 1811, was essential. In this way the Norwegian state, and not the various and old-fashioned local authorities, would have the final responsibility both for the education in psychiatry and the care for the patients.

The quiet life in a rural environment together with practical work on the farm, away from framily and possible causes for the disorder, was supposed to help in the treatment. Optimism was high, based upon the principles of early intervention, and in an advertisement the asylum asked families and doctors to get the patients admitted at the onset of symptoms, as modern

therapy could make the majority of referred patients well again!

Of course, the wards for men (M) and women (K) were separate. And there was a rank order from the well-to-do (A) down to the violent and unsanitary (E), later extended to F and G.

So when seen from above, you had in front a central building with the chief medical officer and the church, and in parallel rows to each side departments with from 14 to 48 beds, first AM and AK close to the gate, with the E wards in the back, surrounded by stone walls.

During the construction works, Major in 1847 took the post as a doctor in the very old-fashioned Oslo Hospital where he advanced to director. This institution had in 1777 erected a building for the treatment of mental disorders, with 16 "cells". This building, however, would seem more like a primitive prison to us, with the sewers running through the central corridor – freezing to ice in the winter – but it was not demolished before the 1930's.

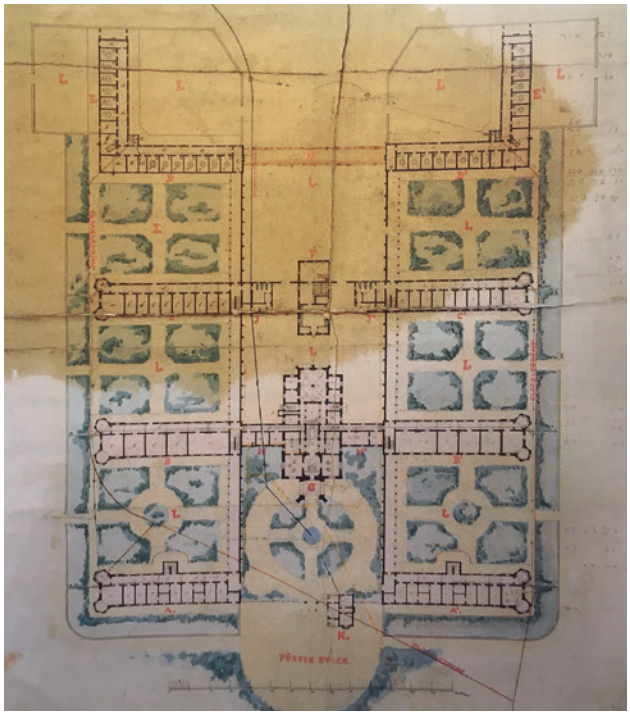
There were a number of similar Bedlams in Norwegian cities, often called "dollhus" from the German word Toll-Haus – literally a house for the insane (and not from Ibsen's play of 1879).

Major visited all of these houses in Norway, and concluded in an 1846 report to the government that they were apt to make the mentally ill more sick, not relieved. Something had to be done!

For this purpose, Major wrote his own draft for a **bill for mental health**. The bill was eventually accepted relatively unchanged, and came into effect as the Insanity Act of 1848 – the revolutionary year in Europe! With some changes over the years, this law remained in place for more than one hundred years, until it was replaced by the law of mental health care in 1961.

When Gaustad asylum was ready for use in 1854, everybody expected Major to accept the post as director of the new asylum. However, he did not. Whether he was under the influence of depression himself after receiving harsh criticism for the expensive hospital with its director's home, where Major had moved in (!) – or whether he feared that Fanny would accuse him of abuse from years before, as some speculate, we do not know.

Instead, he emigrated to America with his wife and children – or this was his ambition, but the ship S/S Arctic collided in the Atlantic, and he drowned with all of his family in 1854, only forty years old.



Original plan for Gaustad asylum. The departments for well-to-do patients in front (bottom), men to the left, women to the right. Photo: Gaustad hospital

But Herman Wedel Major's legacy lives on. His asylum still is a psychiatric part of Oslo University Hospital with specialized in- and out-patient clinics, forensic wards and a prestigious research department. The Major Association was established in the 1970's for psychotherapeutic work in psychosis.

And he should inspire the psychiatrists of today with his belief in human beings: Mental problems can be treated, and recovery is possible! ■

Ola Marstein MD
Practising psychiatrist, Special advisor

My Week in Psychiatry

Algirdas Musneckis

Foreword by Ramunė Mazaliauskienė.
Algirdas Musneckis has recently become a psychiatrist after finishing his psychiatric residency in Lithuanian Health Sciences University. He works as a psychiatrist in the University hospital, Department of Psychiatry, in Kaunas, Lithuania, and he lecturers at the university as well.

In many cases a week of a psychiatrist is quite similar to the week of a common mortal person. We, psychiatrists, are also susceptible to highly prevalent life vices such as hunger, need to sleep and sexual desire, so quite a lot of energy must be committed to these things every day. For my occupational activity, I work in the psychiatric outpatient department, do day and night shifts, and have some seminars with medical students.

Monday. I begin a week at the outpatient department. I started working here quite recently, so there come many manipulative patients who try to achieve their previously lost goals through me. One particular group is called 'benzodiazepine' terrorists. They are more or less addicted to benzodiazepines, that is just another medical condition, not a serious trouble. The trouble begins when they harshly deny being addicted and rejects every possible treatment strategy, they even do not want to talk about how they feel, they just ask for drugs. 'Hey, doc' – one of the patients told me that Monday – 'I came here not to speak about my symptoms or experiment with another class of drugs. Just give me clonazepam and I will go away'. It is quite hard to keep calm and not to show any judgmental sign. It is impossible to help anyone who does not seek help, so members of this group usually leave the department empty-handed.

Tuesday. Day and night shift. I receive a call for consultation in the emergency ward. Two patients, both women. When checked, it appears that they are mother and daughter living together. The daughter has schizophrenia for many years, and the mother has dementia for several years. The daughter feels that thoughts are becoming disorganized again, and she admits to hearing voices. She agrees to be admitted to inpatient ward; however, she asks if I could admit her elderly mother. I ask why. She says: "You know, my mother wants to kill herself". When I ask the mother about her suicide intentions, she tells me: "You know, I am old and dumb, I have no reason to live". They both make their way to the same ward and the same room.

Wednesday. When I come home from hospital, my dog greets me with immense joy; however, she thinks the best I can do after night shift is to go for a walk. Well, the dogs know best, so what can I do, we go out. We, psychiatrists, say to everybody that we do not diagnose our friends and relatives with psychiatric disorders. That's actually a lie. I suspect that even my dog is suffering from PTSD - when she hears something popping or cracking she starts tensely to look for shelter like an old soldier. She also does not like peoples' loud voices and shouting. My dog is from shelter, so I do not know what she experienced in her early years, but as my homeless patients tell me, homeless life is full of dangers.

Thursday. My fiancée and I go to the theatre. Chekhov's Ward No 6 is on display. 'All the world is the stage' – William Shakespeare once said. To this I can add that the best dramas of the world are marked by psychiatric disorders. In this particular staging characters seem to be depicted very realistically looking from professional angle. I feel like I am at work. Perhaps the director had a psychiatrist to consult him for all psychiatric peculiarities of the play.

Friday. I have several seminars with medical students on their psychiatry curriculum. Working with young people makes me feel quite ambivalent. To start with, I like sharing my knowledge, explaining situations,

Algirdas Musneckis MD
Practising psychiatrist, University hospital,
Department of Psychiatry, in Kaunas, Lithuania

thinking, communicating. On the other hand, sometimes I feel hopeless when the audience is sleeping or is secretly lost in their mobile phones, no matter how expressive and interesting I try to be. Today is no exception, end row is sleeping, middle rows are in their cell phones, and first row is watching me a bit suspiciously. I always start with the questions of the topic, I ask what they want to know, what is not clear, what things they want to find out. Usually it is nothing; they came just to another boring day in medical school. Today's topic is suicidal behavior; we have to discuss how to evaluate patient's suicide risk. We start discussing very seriously, and the students seem quite interested, Lithuania is always on top in suicide statistics, so the topic is extremely 'hot'. Suddenly, cats start meowing outside very intensively. One of the students says: 'Doctor, I think I hear strange sounds. Everyone burst with laughter, and I cannot return them to academic tranquility. On the other hand, the students became livelier, woke up and put away their cell phones, so maybe I should put some food outside the window to attract these cats.

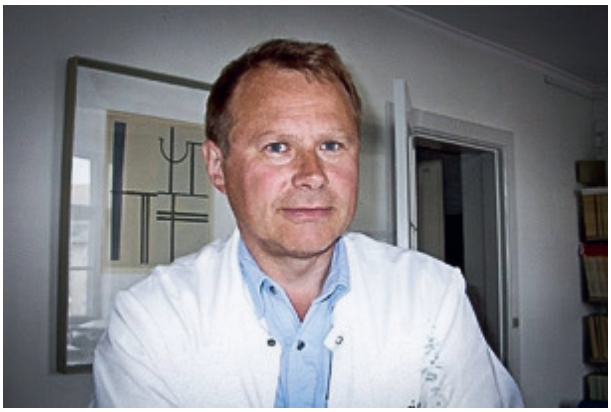
Saturday. I am on duty again. A normal weekend is an envied luxury of nine to five workers; however, I sometimes feel quite obliged to spend weekend at work and not to crowd at the shopping centers. Last shift colleague refers that new patient, young male, is hospitalized with intoxication psychosis. Bad trip, as youngsters say. In this case, it seems like a prolonged bad trip, however at that time we do not know what substances were used, so further monitoring of the patient is indicated. Later in the morning the mother of this patient comes. Soon, the nursing staff informs, that the mother becomes heavily agitated and it seems not clear which of them is the more serious patient. The staff somehow manages to separate them and brings the mother to me. She shortly starts yelling at me: 'Please discharge my son that I will teach him such a lesson he will never dare to become psychotic again'. I did not ask that time what lesson she did have in mind, but somehow, I see her yelling and whipping her adult son with a kitchen rag. In my opinion, this 'treatment' could induce even deeper psychosis, however maybe it is worth clinical trial. I am used to contacting nonplussed patients' relatives, but it is always a challenge. I understand, they are going through denial and anger psychological stages, but the hardest thing is, they did not come to get professional help for themselves, they believe they are the sanest people in the world and they in most cases also think that their precious relative is guilty for getting his condition and doctors are guilty for not treating this condition immediately. So, the basis for constructive dialogue is very poor, but I somehow manage to calm her down that she for a while stops shouting and threatening.

Sunday. I have decided to make some small repair work in one room of my flat. I imagined it would take several days, but I have been doing this for weeks and this nice Sunday is perfect for the wallpapering. When I hang the first piece of wallpaper, it is not in perfect position and looks to have been set up by an amateur. But I think it is ok, you should never expect good results from the first try, and as a beginner scientist I know, that I must try more than several times to make an evaluation whether I am good at wallpapering. However, the next tries are even more disappointing, I am starting to realize that the best option I have is to call the repairmen.

■

Highlights from the Nordic Journal of Psychiatry

Martin Balslev Jørgensen



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

Assertive community treatment is still relevant

Studies have questioned whether assertive community treatment continues to provide a more effective treatment model for severely mentally ill patients in a modern mental health context. This Danish study compares treatment from assertive community treatment with treatment by standard community mental health teams, using a non-blinded quasi-experimental multi-center trial. A total of 366 patients receiving treatment from assertive community treatment (n = 213) or continuation of care from community mental health teams (n = 153) were included in the trial. Assertive community treatment was significantly better in sustaining contact with patients. At 2-year follow-up, 16 (8%) of patients receiving assertive community treatment versus 22(14%) receiving care from standard treatment had lost contact with treatment. Patients who received assertive community treatment had a larger reduction in inpatient service-use, increased adherence to antipsychotic medication, improved social functioning, and higher user satisfaction. No differences in days of involuntary admission and psychopathology were found. The authors conclude that a high fidelity assertive community treatment may be a valuable tool to strengthen contact between severely mentally ill patients and the treatment staff and may contribute to improving outcomes in a modern Danish mental health context.

Thoegersen MH, Morthorst BR, Nordentoft M.
Assertive community treatment versus standard treatment for severely mentally ill patients in Denmark: a quasi-experimental trial *Nord J Psychiatry. 2019 Feb;73(2):149-158.*

Misophonia comorbidity

Misophonia is characterized by heightened autonomic nervous system arousal which is accompanied by a high magnitude of emotional reactivity to repetitive and pattern-based auditory stimuli. This study identifies the prevalence of psychiatric symptoms in misophonia sufferers, the association between severity of misophonia and psychiatric symptoms, and the association between misophonia severity and gender. Fifty-two misophonia sufferers, 30 females and 22 males were recruited in the study and were diagnosed ac-

cording the criteria proposed by Schröder et al. The participants were evaluated by the A-MISO-S for the severity of misophonia and the MINI to assess the presence of psychiatric symptoms. The most common comorbid symptoms reported by the misophonia patients were respectively PTSD (N=8, 15.38%), OCD (N=6, 11.53%), MDD (N=5, 9.61%), and anorexia (N=5, 9.61%). Misophonia severity was associated with the symptoms of MDD, OCD, and PTSD as well as anorexia. The authors conclude that the presence of these varying psychiatric disorders' features in individuals with misophonia suggests that while misophonia has unique clinical characteristics with an underlying neurophysiological mechanism, they may be associated with psychiatric symptoms. Therefore, when assessing individuals with misophonia symptoms, it is important to screen for psychiatric symptoms.

Erfanian M, Kartsonaki C, Keshavarz A.
Misophonia and comorbid psychiatric symptoms: a preliminary study of clinical findings. *Nord J Psychiatry. 2019 May - Jul;73(4-5):219-228.*

How stable are personality traits in psychiatric patients?

This study describes personality traits in psychiatric patients and investigates whether these traits are stable over 13 years. A total of 95 individuals who were patients at a psychiatric outpatients' clinic in 2003 completed the Swedish universities Scales of Personality (SSP). Scores from 2003 were compared with SSP scores from 2016. Based on the current score on the comprehensive psychopathological rating scale - self rating for affective disorders (CPRS-S-A), the participants were divided into two groups representing 'good' and 'poor' current mental states, to investigate the effect of current mental state on reports of personality traits. Out of 13 personality traits, 11 showed a significant change in mean T-score over the study interval. The group with lower CPRS-S-A scores showed a significant change in T-score for 10 traits, whereas in the group with higher CPRS-S-A scores only 3 traits showed a significant change. The authors conclude that the findings support the theory that personality is changeable over the course of life, also in psychiatric patients.

Spangenberg H, Ramklint M, Ramirez A.
Long-term stability of personality traits in a clinical psychiatric sample. *Nord J Psychiatry. 2019 Aug;73(6):309-316.*

Does depression incidence increase?

This national register-based Finnish study was to report the time trends of the age-specific and gender-specific incidence and cumulative incidence of diagnosed depression. The study sample included all 1,245,502 singletons born in Finland between 1 January 1987 and 31 December 2007 and still living in Finland at the end of 2012. The participants were divided into three cohorts by birth year: 1987-1993, 1994-2000 and 2001-2007. Depression diagnoses (ICD-9: 2961; ICD-10: F32, F33) given in 1995-2012 were available and identified from the Care Register for Health Care. Ten percent of the females and five percent of the males were diagnosed with depression in specialized services by age 25 years. The cumulative incidence of depression by age 15 years rose from 1.8% to 2.9% in females and from 1.0% to 1.6% in males when the cohorts born 1987-1993 and 1994-2000 were compared. The authors conclude that a larger proportion of young people in Finland are diagnosed with depression in specialized services than before and suggest that this can be due to better identification, more positive attitudes to mental health problems and increased availability of the services.

Filatova S, Upadhyaya S, Kronström K[1], Suominen A[1], Chudal R Luntamo T, Sourander A, Gyllenberg D
Time trends in the incidence of diagnosed depression among people aged 5-25 years living in Finland 1995-2012. *Nord J Psychiatry. 2018 Nov;72(8):586-592.*

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