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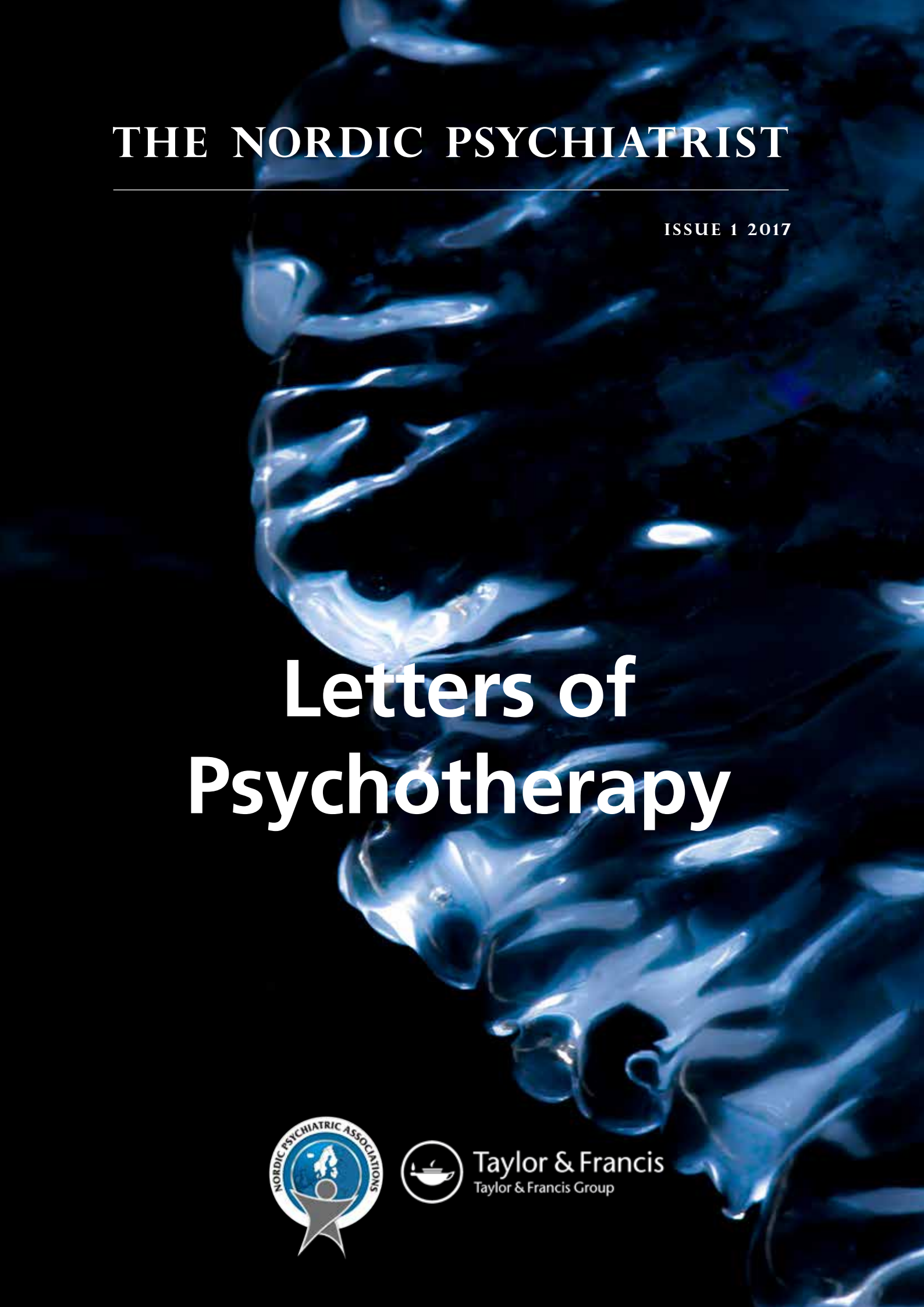

# Letters of Psychotherapy

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# Letters of psychiatry

**Psychotherapy is one of the most used treatment methods** in modern psychiatry. Treatment through verbal communication has been used through the centuries as medics, philosophers, and spiritual practitioners have used psychological methods to heal others. The term psychotherapy derives from ancient Greek “psyche”, meaning spirit or soul and “therapeia” meaning healing or medical treatment. A modern definition of psychotherapy would be "treatment of disorders of the mind or personality by psychological methods”.

Not too long ago, a clinician in psychiatry was expected to choose sides regarding how he or she conceptualised psychiatry, both in terms of diagnosis and treatment. The two standpoints were either the “biological one” – or the “psychotherapeutic one”. The latter was synonymous with the practice of insight-oriented therapies, with the focus on revealing or interpreting unconscious processes. The relief of symptoms was not the main focus of the treatment, but to unveil the unconscious conflict.

For years, psychodynamic therapy was the only therapy of choice. With time new methods arose, and were scientifically evaluated. As the concept of evidence entered the stage, psychodynamic practitioners were challenged by therapists using cognitive-behavioural and systemic techniques. Over the last decades, numerous therapies have been introduced.

**Initially, psychotherapy was performed by doctors.** Over the years, psychologists have become more or less synonymous with psychotherapy. Today, fewer doctors are trained as psychotherapists, and it is often debated to which degree psychotherapy should be a part of specialist training in psychiatry.

Earlier assumed harmless, the potential side effects of psychotherapy are nowadays highlighted in a new way, comparing them with drug therapy. The way psychotherapy is regulated varies much from one country to another.

There is a broad spectrum of psychotherapies to chose from. In this issue, our aim is to provide you with an overview of the ones most often used. Many therapies today are referred to as different abbreviations of “letters”. We asked practitioners to write a letter to a colleague explaining the therapy they perform.

As always, you will in this issue read about the recently published articles in the Nordic Journal of Psychiatry, and get a report from what is going on in the Nordic Psychiatric Associations. It is with great joy I present this very informative issue of *The Nordic Psychiatrist* to you!

**Hans-Peter Mofors, Editor**

# Talking to the Patient

Andres Lehmets

**Psychiatry stems from different ideologies.** Biological psychiatry has its roots deep in the medical model. There is a pill for every disease and evidence-based treatment models provide clear guidelines for treatment and cure. Psychotherapeutic approaches are much less organised – psychodynamic thinking has been gradually surrendering its positions to other therapies and psychotherapy is no longer the monopoly of psychiatrists.

I started my career during the years of the years of Soviet Empire. The society ruled over the individual and psychiatric diagnosis lead to restrictions rather than understanding. Freud represented the decadence of the West, the closest that "psychotherapy" came to was hypnosis. All this changed when the iron curtain opened. In a few years time different training opportunities were opened, mostly with the help of colleagues from Nordic countries. Psychotherapy became available for the treatment of mental disorders and also outside medical quarters – as a tool of empowerment and for improving self-esteem.

UEMS sees psychotherapy as an integral part of training in psychiatry. This is also the common practice in most European countries, but at the same time there are differences in the substance and format. It is often the case that more thorough training is provided outside the academic medical setting, by psychotherapeutic institutes and associations. Neither is there a common certificate of psychotherapist that would enable cross-border recognition as there is for medical specialities.

Over the last decades the understanding about the interaction of the mind and body has developed substantially. This has also helped to understand psychotherapy and do develop further more structured and evidence-based psychological interventions. But this has also raised issues on reimbursement of several, particularly long-term therapies that used to be a well-accepted golden standard in the past.

Modern technologies open new possibilities for psychotherapy and counseling. Internet-based techniques can make them more accessible, but they will probably never fully substitute the traditional contact between the patient and the therapist. It is the human contact that has made psychotherapy work.

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

Psychotherapeutic understanding of mental disorders is essential for assessment and treatment of patients with mental disorders. Establishing and maintaining the therapeutic alliance is the basis of any psychiatric treatment, not only psychotherapy.

The talking cure is here to stay. ■

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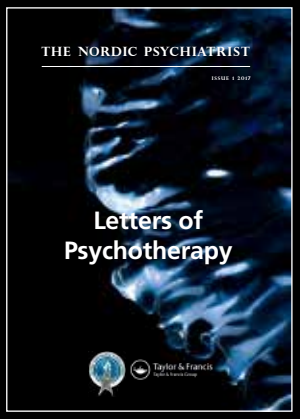



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# A rough blueprint for national treatment guidelines

Rolf Sandell

**Despite the beliefs of a number of sceptics we know now that psychotherapy, in general, is an *efficacious* type of treatment, as shown in RCTs, and also an *effective* type of treatment, as shown in naturalistic studies. Thus, the average outcome of the active treatment has been found significantly superior to the average outcome in some control no-treatment condition. But that does not necessarily mean that the difference is large or that the outcome of the active treatment is *clinically* significant. Let us look more closely at the findings.**

**In fact, the rate of** *non-response* to psychotherapy, whatever the method or the "brand," hovers around 50%. A naturalistic study in the US a few years ago, with almost 7000 cases with almost 700 therapists of various orientations, found that between 25% and 60% (depending on the outcome measure) of the patients did not change reliably within 16 sessions. According to an academic thesis of this year on negative effects of internet-based cognitive behaviour therapy (CBT), 32 to 90% of the cases did not respond reliably at termination and 29 to 87% did not at follow-up. The author concluded, "This is in line with what is expected in CBT delivered face-to-face, which suggests that about half the patients do not respond." And that is *probably* true for other brands of therapy than CBT as well. When outright deterioration is concerned, the US study found that from 8 to 32% deteriorated reliably, in the sense that they came out worse after treatment than they were to begin with. The CBT study reported a relative frequency of 6% negative changes, which matches the estimate of such an outcome that is nowadays generally taken as valid, that is 5-10%. Further, roughly 10% (at an average; 0 – 58% in different studies, according to a meta-analysis published this year) do not show up to start a treatment that has been agreed on, and roughly 20% (0 – 69% according to the same source) drop out without finishing it. So, all these figures seem to reduce the rate of response to around 30%, only, even for treatments that are considered "evidence-based"!

I present these figures in such relative detail because they are indeed alarming and need to be known. They are also astonishing given the fact that so many studies have shown that the majority of patients prefer psychological treatments to medical ones. One interpretation might of course be that this majority is misled, by the media, by some psychotherapist lobby (if there is one), or on ideological or kind of humanistic grounds, and that the sceptics are correct. Another interpretation is that psychological treatment in itself is what it promises to be *in principle,* although it is too often delivered by incompetent providers. There is indeed robust re-

search findings to show that this is lamentably true—from 0 to 16% of the therapists in the naturalistic US study that I mentioned above were classified as harmful, and the variation in mean outcome among therapists is generally found considerably greater that the variation among treatment brands. A third interpretation—and one that I favour—is that most of the therapeutic failures are due to mistaken treatment indications, that is, patients are unsystematically or stereotypically assigned to a "wrong brand," to a kind of therapy that does not match their needs and resources.

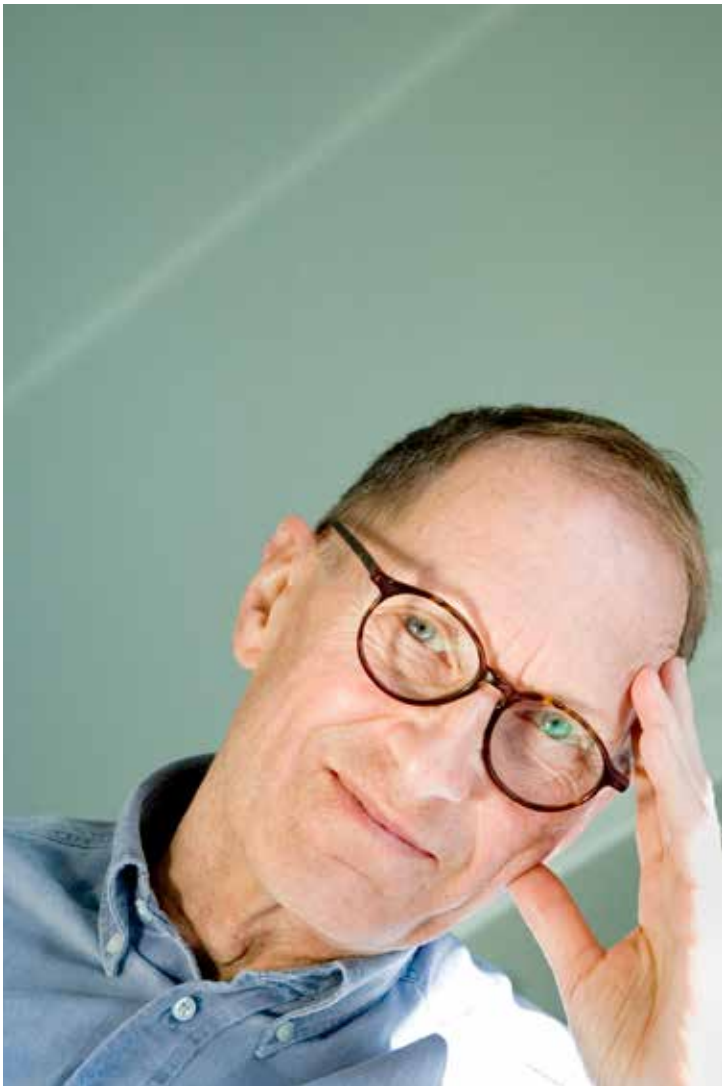
This interpretation is based on the assumptions that patients, like people in general, are different, and that what may appeal to some patients in terms of treatment may not appeal to others. One of the internationally most established CBT researchers, Robert DeRubeis, in a paper just published has formulated it as follows: "[A] sound argument for not limiting psychotherapeutic options to CBT or any other single treatment is that no approach will work for all individuals. Thus, it is essential that alternative approaches are available for those who fail to benefit from the initial treatment." What is required, then, is *personalised or customised treatment*.

If that is correct, the solution would require an assortment of different types of treatments available, to begin with. This is really not a problem, as someone once counted up to several hundreds of different brands of psychotherapy—and I believe that the assortment has to include a variety of biological brands as well. And among the psychotherapies there are at least a handful that are well established.

Then, critically important, the solution would require an empirically grounded system for assigning patients to treatment varieties that are individually suited. It has to consist of two interlocking parts. One is a systematic treatment assignment system based on empirically established finds of predictive and moderating variables. There are some such systems at work already, such as Beutler's *Systematic Treatment Selection,* and DeRubeis' *Personalized Advantage Index*.

The second part is a continuous feedback system that conveniently and reliably will inform the therapist or the clinic whether the treatment is on track or not. Because if not, the patient should be reassigned to some alternative treatment or approach. A computerised such system is not methodologically difficult to develop, but it will require the expertise of system developers and a very large number of cases to establish psychometric norms. A couple of research projects in Sweden and Norway are underway and may fulfil these requirements for Nordic populations in due course of time.

It is along these lines of thinking that I would like the national guidelines in our countries to be developed. ■



**Rolf Sandell**
Professor of Clinical Psychology and
Senior Research Fellow, Lund University

# Cognitive Behavioral Therapy today

Guðlaug Thorsteinsdottir

**Since over 100 years of the history of psychotherapy it has been well documented that psychotherapy works, but still has limitations. This has resulted in the development of todays' about 400 different branches of psychotherapy available.**

**Guðlaug Thorsteinsdottir**
Specialist in Eating Disorders, Certified in Cognitive Behavioural Therapy,
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Iceland

**Fierce debates** have been on which theoretical orientation is the best, but with no real consensus. Cognitive Behavioural Therapy (CBT) emerged from Aaron Beck in the sixties and has for the past 20 years been embraced as the best evidence-based practice for many mental disorders. The drive behind this has been demands for more cost-effective therapies, primarily originating from the USA. CBT was in a way revolutionary, and offered a time-limited, problem-focussed treatment, with emphasis on an active working-relationship between patient and therapist. For many therapists this was also very appealing as opposed to the endless, seemingly aimless, sessions in psychoanalysis. Further, CBT is one of the most (probably *the* most) extensively researched form of psychotherapy, demonstrating effects and claiming in many cases superiority over other therapies, especially for anxiety and depression (numerous meta-analyses, including Tolin 2010, Marcus et al 2014, Mayo-Wilson et al 2014).

All this has had implications for policy-making, clinical guidelines, curriculum in psychology and medical schools and not least a biased funding towards training professionals in CBT. It is without doubt the most widely used psychotherapy approach today together with its offspring Mindfulness Based Treatment (MBT, or DBT). No psychotherapy has had as successful marketing as CBT with its many branches. At the University Hospital Landspitalinn in Iceland, for example, there are practically no other psychotherapy options available in adult psychiatry. Should a patient need another approach, or wish for one, he has to seek the private sector and pay fully himself. For those patients who still want CBT but have tight budget or limited access, CBT has been watered down into various self-treatment programs online and self-help books like "Cognitive behavioral therapy for dummies" and the "Overcome" books and "Feeling good" books. So CBT fits all.

But is CBT the answer to all our patients needs? Critics of CBT have come forward, researchers and clinicians on both sides of the Atlantic. A recent summary of the three CBT meta-analyses cited above was quite critical when scrutinizing the methodology and conclusions made (Wampold et al, Nov 2016). Their bottom line was that there *is no evidence, or at most weak evidence limited to the targeted symptoms,* for the superiority of CBT to other psychotherapies. Replication studies have also failed (Nosek 2015) and it is well documented in clinical reality that CBT only works in roughly about 50% of cases, with drop-outs often reported in 25-40%. Moreover, most of our patients have comorbidities with complex symptoms, and different approaches are needed. Have we stopped working with the possible *cause* for disorders, and doing assessments of psychopathology and personality since it is too time-consuming and doesn't fit the manual?

CBT has certainly developed and tried to adapt to the complex clinical environment but we need to ensure that other treatment options are available for those who do not "fit in". We have to listen to our patients and tailor therapy to *their* needs and not to the needs of the system. Focus on quality, not quantity. In the long run, it is both cost-effective and will save many patients from suffering. The "short-term therapy fix" isn't always working.

We are back to basics. Still, the therapist skills most strongly predict outcome in psychotherapy – the ability to establish working alliance and empathy with the patient. It is our responsibility to ensure that we can offer flexible treatment options and trained therapists with broad therapeutic skills for the benefit of our patients. ■

# Conversation therapy in old Icelandic writings

Óttar Gudmundsson

**Óttar Gudmundsson**
MD psychiatrist. Landspitalinn, University Hospital, Reykjavik Iceland.

**The Icelandic Sagas and other contemporary literature from the 13th and 14th centuries are the most impressive contribution by Iceland to the world literature. These stories are about the struggle of survival of the settlers and their families in the new country.**

**These stories are characterised** by discord and fighting, yet also by friendship, honesty and interaction between people in good times and bad. The Icelandic Sagas have always been very popular in Iceland and the persons in the Sagas were the models of people for centuries in their harsh daily lives. Other famous books written in Iceland include the Nordic mythology and Hávamál *(The Words of Odin the High One)* are a collection of sound advice as stated by Odin himself. According to the Icelandic Sagas, keeping your sorrow and grief within was considered a major virtue. One should never allow others to see into one's soul and innermost thoughts. The Viking had to avoid showing his weaknesses. Yet, at the same time people were encouraged to open up to others to some extent as we do today. Hiding your feelings inside was deemed as being dangerous. One of the verses of Hávamál reads as follows:

*Sorg etur hjarta*
*ef þú segja né náir*
*einhverjum allan hug*

This translates informally as follows:

Grief consumes your heart
if you cannot speak your full mind
to someone

Actually, here a very fine line is drawn, namely much harshness stuns you as it overwhelms your will of life and causes mental distress. Excessive exposure is considered as a vice.

The Icelandic Sagas contain various stories about the importance of dialogue for resolving and accepting cruel fate. One of the best known examples of such conversation therapy is contained in the segment about Ívar Ingimundarson. Ívar and his brother, Thorfinnur, were courtiers of King Eysteinn of Norway. Ívar was engaged to a young woman named Oddný. Thorfinnur journeyed to Iceland and Ívar asked him to bring his best regards to his betrothed and to tell her to wait for him. Thorfinnur did not convey such a message; instead he proposed marriage to her. She accepted as she had no news of Ívar. He, however, heard of these events and sank into much depression over this betrayal by his brother and betrothed. King Eysteinn immediately noticed his courtier's grief and asked him what was wrong. Ívar told him about the marriage of Oddný and Thorfinnur. The King suggested that Ívar should seek other beautiful women; however, Ívar said he could not. The King invited him to have a daily dialogue with him about this woman. He said that any grief and sorrow would become easier to bear if discussed regularly. The King furthermore

wanted to give Ívar a gift on every occasion they met for their conversations. Ívar accepted and the two of them discussed Oddný the whole winter. The Saga says that gradually Ívar recovered and became his joyous self.

This story is told as an example of the virtues and intelligence of King Eysteinn, and his kindness to his courtiers. The author of this Saga emphasizes his insight into human nature. The King realized that the only way Ívar could overcome his loss was to talk about it. This therapy by the King is unique, compared to today's methods, in that he gave the patient a gift at the end of every session, which in turn increased the value of the therapy. Nothing is reported about the King's answers; however, he was obviously a keen listener.

The Sagas frequently report on long conversations between people during grievous times in their lives. Emphasis is placed on the value of such dialogue and human closeness in times of trouble. Fatalism prevails in the Sagas. Much focus is placed on people's lack of defense in respect of their own fate and on the necessity to accept life and its harsh terms.

Hávamál *(The Words of Odin the High One)* frequently emphasizes the value of human interaction and conversation.

> Young was I once, I walked alone,
> and bewildered seemed in the way;
> then I found another and rich I thought me,
> for man is the joy of man.

Also in Hávamál:

> Hast thou a friend whom thou trustest well,
> from whom though cravest good?
> Share they mind with him, gifts exchange
> with him, fare to find him oft.

The message of this verse is the value of friendship because friends can talk and thereby share each other's burdens.

The authors of the Icelandic Sagas and Hávamál are well aware of the importance of dialogue and friendship in resolving problems and addressing depression. The line drawn is extremely fine. Do not say too much, yet do not lock your grief and worries inside. This is old truth that has proven its value throughout time. ■

# Dangers in psychoanalysis

## Clinical example

Óttar Gudmundsson

**Óttar Gudmundsson**
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**Psychoanalysis never earned footing or popularity in Iceland. Freud's books were translated into Icelandic and some psychologists worked on grounds of his theories, yet they never became a part of the therapeutic community.**

**One psychiatrist, Dr. Esra Pétursson,** practiced and emphasized psychoanalysis. He was educated in the United States whereas he subsequently moved to Iceland after many years of practice in the New York area. When he returned to Iceland he began practicing in Iceland's capital city, Reykjavík, treating his patients mainly at his private offices. Dr. Pétursson published his biography in 1997, writing about his studies and professional activities, as well as his colorful love life. In his book Dr. Pétursson discusses an incident that had dramatic consequences for him and many others. The patient was a young woman, some 40 years younger than the psychiatrist. She had several symptoms of serious personality disorders, behavioral problems and anorexia. Dr. Pétursson treated the patient through psychoanalysis on a couch, three times per week to begin with, however, less often as time went by. Initially, there was much negative transference of emotions towards the psychiatrist, which gradually became more positive and sexual.

He tried to work on these emotions through psychoanalytic methods, discussing transference and counter transference in their interaction. The woman understood this well, however, her feelings for Dr. Pétursson did not change. She said she loved him and this admiration by such a younger woman went to his head. His marriage was going through a crisis and the patient's attentions fueled his narcissism. She said during one of her sessions with the doctor that she had dreamt about him last night and that they had been making love. Dr. Pétursson describes in his biography how he lost control of the situation – the male and sexual being removed all power from the psychiatrist who stood up and entered his patient's sexual dream and thus made transference real. This was the beginning of a love affair between a patient and a doctor ending in them having a child together. This caused must stir and the patient committed suicide some years later. Dr. Pétursson was married at the time; hence this was construed as a major scandal.

In his book Dr. Pétursson tells this story for the first time. He had managed to avoid penalty by the Icelandic health authorities when this situation occurred, i.e. by maintaining that his treatment of the patient had ended before their love relationship began. This revelation generated major and immediate reaction. Dr. Pétursson lost his medical license and was expelled from the organization of psychiatrists and doctors in Iceland. His conduct was deemed both as having been unacceptable and unethical. Dr. Pétursson left Iceland soon after this and settled in the United States where he passed away some time later.

Dr. Pétursson says in his book that sexual transference is rare in psychoanalysis. Obviously, he was by no means able to address these emotions in his patient; instead he entered the dream she described to him. The consequences were extensive and dramatic for everyone. This case illustrates the need for every psychiatrist having some venue where he or she may discuss ethical issues that may arise during therapeutic sessions. ■

# The limited evidence for effectiveness of psychotherapy

Joar Øveraas Halvorsen

**It is often assumed that the evidence base for psychotherapy is relatively good and that psychotherapy is relatively effective for a number of mental disorders. For example, Wampold and Imel [1] recently argued that we know for *sure* that psychotherapy is *remarkably effective.* However, as I will argue in this brief commentary, the evidence for the effectiveness of psychotherapy is not as satisfactory as is often assumed. To the contrary, there is substantial uncertainty regarding the effect estimate of psychotherapy.**

**In order to attest** the effectiveness of any treatment, we need clinical trials of adequate methodological quality. Due to the potential bias introduced in trials of inadequate methodological quality, we need to interpret effect size estimates obtained in these studies with great caution. And it is a rather consistent finding from clinical trials in general, that trials with low or poor methodological quality (and thus high risk of bias) tend to overestimate the effects of any given treatment.

A recently published umbrella review of meta-analyses of psychotherapy randomised controlled trials found that out of a total of 247 identified meta-analyses, only 16 (7%) met methodological criteria necessary for providing what the authors defined as convincing evidence for the effectiveness of psychotherapy [2]. In other words, the majority of meta-analyses of psychotherapy do not provide adequate evidence that psychotherapy has the effects that are often assumed. This does not necessarily indicate that psychotherapy is not effective, but that there is substantial uncertainty regarding the effect estimates achieved in most studies.

In another informative study, Cuijpers and colleagues [3] investigated how many randomised controlled trials of psychotherapy for depression that met eight rather basic methodological quality criteria. Of 115 clinical trials identified, only 11 trials met all eight quality criteria. Thus, only a minority of clinical trials investigating the effects of psychotherapy for depression has adequate methodological quality. The effect

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size for the trials not meeting all the quality criteria was 0.75. However, the effect size estimate from the trials meeting the quality criteria was substantially lower (SMD=0.22).

Meta-analyses of psychotherapy assessing methodological quality consistently find that (1) the majority of psychotherapy trials have sub-optimal methodological quality making them susceptible to bias, and (2) there is a negative association between the methodological quality and the estimated effect size of treatment, i.e. that higher methodological quality is associated with lower effect size estimates [4-11].

A number of different challenges pertaining to psychotherapy clinical trials also contributes to uncertainty regarding the effect size estimates: publication bias [12, 13], flexibility in the collection and analyses of data especially in the light of the low number of trials prospectively registered in clinical trials databases [14, 15], low statistical power [16, 17], and that patients enrolled in clinical trials of psychotherapy are allowed to stay on stable doses of psychiatric medications [18].

Although we acknowledge that conducting methodological stringent and rigorous randomised controlled trials of psychotherapy is excruciatingly difficult, we should not ignore the fact that the majority of clinical trials of psychotherapy is characterised by inadequate methodological quality leading to substantial uncertainty regarding the effect estimates obtained in most psychotherapy trials. As pinpointed by Dal-Ré and colleagues [19], we need to interpret the findings from clinical trials of psychotherapy with prudence. ■

# Systemic family therapy in Latvia

Ilona Buša

## The history of family therapy in Latvia

**In Latvia, family therapy began in 1995. The first lessons were offered and provided by educated and licensed family therapists and supervisors: Linde von Keyserlingk, Arist von Schlippe, Michael Grabbe, and other family therapists from Osnabrück University in Germany. The father of Linde von Keizerlink is from Latvia, Kurland. Because of her heart-warming willingness and initiative to give her professional knowledge to Latvian people, family therapy was able to enter Latvia in 90's. Arist von Schlippes father also has lived in Riga in his childhood and still remembers Latvian folk song "Kur tu teci gailīti, mans". Linde and Arist received Honour award from Latvian systemic family therapy association in 2015 and are honoured members since 1999. Thanks to family legends and kind feeling towards Latvia, we have German "mother" Linde and German "father" Arists. We have highly professional and friendly relationship for more than 20 years.**

**Nineteen family therapists** and two family consultants were trained with different basic educations – psychotherapists, pedagogues, social workers, physicians and also one with a background in theology. This project was carried out with help from the Latvian Family Centre and its former director and psychotherapist Anita Plúme. In 1999, the first Latvian family therapists received Osnabrück and Latvian post-doc training and Institute diploma. In the same year Lindes von Keyserlingk curriculum was awarded from Weinheim family therapy institute 'For work in tough conditions'. Twenty-two more therapists were qualified in 2004. It was performed by the head of the program – Jurii Mannik, child therapist and family therapy professor from Stockholm (Sweden). This project was sponsored by East European Committee (Sweden). Today there are 62 members of our association. The majority of them reside in Riga.

### Association

In 1997, Latvian Systemic Family psychotherapist's association (LSFTA) was founded; homepage <www.gimenespsihoterapija.lv>. The same year LSFTA become as member of Latvian psychotherapist's association (LPB – a national psychotherapists association, and became a member of EPAs in 1998.

**Quotes on family therapy or by family therapists**

"Certainty is an enemy of change "
***Salvador Minuchin***

"One of the most important aspects of family dysfunction is an equal degree of overfunction in another part of the family system. It is factual that dysfunctioning and overfunctioning exist together "
***Murray Bowen***

"Only the family, society's smallest unit, can change and yet maintain enough continuity to rear children who will not be "strangers in a strange land," who will be rooted firmly enough to grow and adapt "
***Salvador Minuchin***

**Ilona Buša**
Clinical psychologist, systemic family psychotherapist, systemic supervisor in education, Marte Meo method supervisor, Riga, Latvia, board member in EFTA-NFTO

Family therapy as well as eight other psychotherapy schools are not officially recognized and have no legal base, since most members lack medical education. Since the 90's there is a monopoly in Latvia of the word "psychotherapist", which is considered to be a medical specialization. LPB has struggling for legalisation almost for 20 years, but till now without success. In 2006, Latvian Family therapist union was enrolled in Europe FAMILY Therapy union (EFTA).

**Training programs**

When 10 therapists had qualified, a study program in family therapy was created ensuring quality education. In 2009/2010, 17 new colleagues had been qualified in systemic family therapy. In 2011 and working together with Essen Systemic Family Therapy in Germany, 21 more persons got qualified in family therapy. In 2011/2012 two new training programs were started. The first one was organised together with the Essen institute, and the second one was realised by 'Family psychotherapist co-praxis' working together with Weinheim systemic therapy institute (Germany). At the end of 2015 24 more specialists were qualified.

**Current situation of family therapy in Latvia**

All 62 members have private practices. The payment is made only by clients themselves, and very seldom by their insurance companies. National benefits for families in need of guidance do not exist, except those for socially problematic families. Twenty colleagues are working in educational system, most of them in schools, some in universities. Introduction into systemic family therapy is available in university lection offers. Sixteen family therapists work in the social system.

The Association is active in the society, organizing open conferences. Members have participated in Riga's town hall public projects in 2014-2015 with public lectures for parents on nonviolent resistance against aggressive minors, positive guidance and development for children. Three therapists work in the health care system, and 30 work on an organizational level – supervising and consulting. ■

# Systemic family therapy in Lithuania: from its beginning up to now

Laura Tamulevičė

**Systemic family therapy is a quite new and not very well-known psychotherapeutic trend in Lithuania. Yet it already has its history, present activities, and future plans.**

**Family therapy in Lithuania – historical aspects.**
In 1969, a family relationship counselling office acting was opened in on voluntary basis. In 1979 the first professional family counselling office started to provide consultations in Vilnius Civil Registry Office. After regaining independence, in Vilnius eight private institutions were providing support to the family in 1992.

The majority of family therapists have started from individual psychotherapy. Sixteen professionals (psychiatrists, psychologists, and social workers) have been trained as family therapists in 2000-2004 by initiative of the Nordic Council and Kaunas Medical Institute. Trainings were provided by Estonian Family Psychotherapy Association and invited lecturers from Norway, Finland, and Sweden. Yet in 2000 even more specialists, including nurses, participated in introductory course of Systemic Family therapy as a part of Early Intervention into Acute Psychosis project held in Žiegždriai mental hospital and supported by the Council of Kaunas region. The project was based on ideas about reflecting process (prof. T. Andersen; Tromsø University, Norway).

In 2004, the Institute of Family Relations, IFR, in cooperation with the Kaunas Medical University (today Lithuanian Health Sciences university), started an Introductory Course (72 hours) of Family Psychotherapy. One hundred and two students finished an introductory course during 2004-2012. In April, 2013, the Institute of Family Relations, IFR, started a four-year study program on Couples and Family Psychotherapy (in cooperation with ISCRA (Scuola di Psicoterapia sistemica relazionale) and the (Family Institute at the University of Glamorgan, Cardiff).

**The Lithuanian Systemic Family Therapy Association**
was founded in 2002 as a consequence of the education held in Kaunas, where the first family therapists in Lithuania received their training. The association had aspirations but inhibited its activities and was disbanded in 2011. It was re-established by the initiative of present Chairperson Laura Tamulevičė and with the agreement of previous members that re-joined the association in 2012.

**The present situation with family therapy in Lithuania**
There has been no law governing the professional activities of psychotherapists until now. The psychotherapeutic practice is still considered to be an exclusively medical practice, a so-called "narrow medical practice", and only physicians are licensed to provide psychotherapy.

A psychotherapy law development initiative group was established in 2011. The initiative was to create a rule base for the profession of psychotherapist as has been done in other EU countries. The initiative group

**Quotes on family therapy or by family therapists**

"We get together on the basis of our similarities; we grow on the basis of our differences "
***Virginia Satir***

"The overall goal [of counseling] is to help family members become 'systems experts' who could know [their] family system so well that the family could readjust itself without the help of an expert "
***Murray Bowen***

"Your responses to the events of life are more important than the events themselves "
***Salvador Minuchin***

**Laura Tamulevičė**
Chairperson of Systemic Family Therapy Association, certified systemic psychotherapist

was created of the representatives of various psychotherapist organisations that expect to participate in the professional reglementation of the speciality of psychotherapy.

The law foresaw the establishment of the "umbrella" organization – Lithuanian Psychotherapeutic association (LPtA) – for the psychotherapeutic associations representing different trends in psychotherapy. Implementation of the Law of Psychotherapy has met with many bureaucratic obstacles and adjustment of interests.

The Systemic Family Psychotherapy Association is an active participant of this process. The role of the association in this process was to make a decision to join LPtA and represent the members of association in the psychotherapeutic community and to ensure their rights (2013) and to negotiate on acceptable conditions for the members of association.

Final remarks: the Law of Psychotherapy will regulate the licencing of professional practice, requirements for the competences, educational conditions, and duration. The Register of psychotherapists, Ethic board, responsibilities and rights of the psychotherapists will be created. It will be a historical step for Lithuania – legitimising the independent specialty of psychotherapist.

Education of systemic family therapists is mainly held by the Institute of Family Relations, IFR, based in Kaunas. The education started with 2000 hours. In 2015 program was revised according EFTA recommendation (2800 hours). The teaching staff comes from Lithuania, Italy, United Kingdom, Sweden, and Iceland.

Future plans and challenges. In general, our future plans concern strategy, legislation issues, representation ("marketing") of the name of association and systemic family therapy, collaboration at all levels – family, community, system, and country, international, education, and research.
In particular, these plans are:

1. To represent members of the association in all legislation processes.
2. To collaborate with the institutions and organisations in Lithuania and international organizations in order to deliver integrated and qualified help to the families.
3. To represent the Association in all important events in Lithuania and abroad for psychotherapy in general and for systemic family therapy in particular.
4. To spread the ideas of systemic family therapy among the community, specialists, students.
5. To work with educational issues and to create educational program.
6. To participate in research – qualitative or quantitative. ■

# Encountering religious and spiritual themes in psychotherapy

Peppi Sievers

**I have worked as a clinical psychiatrist and psychotherapist for almost twenty years. I have also studied theology and I am ordained priest in the Lutheran Church of Finland. So, I have been interested myself for a very long time in finding and even creating bridges between psychology and theology or spirituality. During my training as a psychodynamic psychotherapist and later psychoanalyst I noticed at several occasions that religious and spiritual themes and questions of patients are still somehow very special to the therapists. This is somewhat negative in nature. For instance, it is quite common that psychotherapists do not consider these themes to belong to psychotherapy at all. At the same time, many patients consider religious and spiritual themes and questions very important in their lives and want to process also these themes in their psychotherapy. I have often wondered why these themes are so special, and sometimes even frightening to the psychotherapists themselves.**

**This speciality of religious** and spiritual issues bothered me so much over the psychoanalyst training years that I felt I had to study these phenomena further. This developed into my pastoral-psychological (branch of theology) dissertation, which was finished last year (2016). In this qualitative study I interviewed 20 qualified Finnish psychotherapists. I analysed interview transcripts focusing to the transference and counter-transference issues in the therapy interaction. Psychotherapists' own preconceptions and attitudes could be shown to somehow negatively interact with the therapists' capacity or skill to work with these themes. Influences of psychotherapists' own therapy and supervision of his or her capacity to work came to the forefront. So, my main interest was all the time how therapists work with their patients when these themes emerge in the treatment. I was not interested in their own religious beliefs or their own concept of God.

One characteristic of the religiosity in Finland is the strong tradition of revivalism. For people belonging to these movements, beliefs and "accepted behaviour in the community" are strictly confined, for instance as for sexual behaviour. Moreover in recent years, there have been several studies and discussions in the me-

**Peppi Sievers**
Psychiatrist, Psychotherapist, Psychoanalyst (IFPS), Doctor of Theology, Pastor in the Lutheran Church of Finland

dia about sexual abuse in these religious movements. Media has also been filled with narratives of very bad "handling" of sexual abuse cases inside the movements. For example there has been long periods of attempts to silence victims and protect the perpetrators. This kind of articles and discussions in the media will form psychotherapists' attitudes, preconceptions and beliefs concerning religious people.

One of my research findings was related to psychotherapists' work with patients who belonged to some of these revival movements, or with people who had separated from these movements as adults. This kind of separation from the strict community is at the same time intense emotional, spiritual and a social makeover to the person. Some of the therapists did not process the spiritual or religious dimensions of this separation at all, because they considered it only as social separation. Some of the therapists did not even take these patients to therapy because of their own attitudes and beliefs. So, in my research, psychotherapists preconceptions and convictions about habits and beliefs in these revivalist movements could lead to too strong emotional reactions in their mind, so therapy could not possibly get started.

This subject has previously seldom been studied in qualitative or even empirical ways. My research was unique also in focussing interest to the psychotherapists and how they encounter these questions and themes.

One of the main findings in my study is that psychotherapist should keep their own mind open and free of preconceptions while working with religious and spiritual themes of their patients. Otherwise there could be some obstacles or problems in working with these issues, and the patient cannot get full benefits of the treatment. The aim of the all kinds of psychotherapy is to open access to one's own mind. If some of the important themes should be left outside the therapy, this could lead to disintegration, not integration of the mind – which is the aim of psychotherapy. It is the therapist's duty to process his or her mind so that the capacity to work can be maintained in every field where a patient needs help. ■

# Does psychological treatment of convicted offenders of child sexual abuse reduce recidivism?

Jarna Soilevuo Grønnerød
Cato Grønnerød

**There exists an enormous amount of individual studies, reviews, meta-analyses and even reviews of meta-analyses conducted in the last 40 years investigating whether psychological treatment of convicted offenders of child sexual abuse reduces recidivism. Yet, the result remains the same. Research with high methodological standard does not show any positive treatment effect, while studies with low standard tend to show a minor effect, often seen as "promising" by authors.**

**We suggest asking** the other way around: If there is a true treatment effect out there, why is it so hard to find in high quality research? In our view, the most likely answer is that there is no recidivism-reducing treatment effect. Treating convicted offenders is not the answer to reducing child sexual abuse. We suggest that early interventions, prevention and after sentence supportive measures should be given priority.

Treatment providers tend to criticize these negative findings and argue that they experience positive change in their clients and strongly believe that their work reduces recidivism. The problem with studies and clinical experience is the low base rate of sexual offending. It is estimated that even with no treatment, recidivism is about 15-20%. Treating the remaining 75-80% of offenders will not tell anything about treatment effects – it is the treatment of the small minority that counts. Sadly, clinical experience often labels a few cases of recidivism as exceptions, while from the researcher's perspective this equals no treatment effect.

Treating convicted sexual offenders may have other positive effects, as increased quality of life and reduced psychiatric symptoms. When faced with the strong reactions from the general public against child sexual abuse, it may be easier for treatment providers to argue that there is a recidivism reducing treatment effect than defend the offenders' right to increased quality of life. ■

**Jarna Soilevuo Grønnerød**
PhD, lic. clin. psychologist, University of Oslo
**Cato Grønnerød**,
PhD, lic. clin. psychologist, University of Oslo

# The role of psychotherapy in modern psychiatry

Halldora Olafsdottir

**Halldora Olafsdottir**

**Psychotherapy or some form of psychosocial support has always been an important part of psychiatric treatment and probably always will. During the past 30-40 years we have seen major changes in our understanding of psychological suffering and mental disorders. We have moved from the dichotomy of the Kraepelinan descriptive, biological model on the one hand and the pure psychological models on the other pole to a more integrated understanding of how innate biology and environmental factors are intertwined in the development of mental suffering.**

**As psychiatrists we used to** train and define ourselves mainly as either biologists or psychotherapists. The biologists were mainly hospital based and treated the more severe mental disorders, like schizophrenia and severe mood disorders. But the psychotherapists, most of them psycho-dynamically oriented, were based in outpatient clinics or private offices and treated the more common forms of mental suffering, like depression, anxiety, and personality disorders. In the nineties, "the decade of the brain" we saw a major shift toward biological psychiatry, especially evident in ever more drug treatment for mild to moderate conditions that previously had been treated with psychotherapy or a combined approach. This development was fuelled by the drug companies making profits on the new antidepressants and antipsychotics. The psychiatrists were bombarded with "new research data" on the benefit of the new drugs comparing to the old ones and the ever widening range of new indications for their use. The sales rates scored and in some societies one out of ten adults were taking psychotropic medications and most of those using the medications for years. Lately, some of this data has been questioned, even to the point of showing very little benefit of the SSRIs, if you add together relatively low response rate and bothersome side effects.

With the more biological and research-based approach, psychodynamic treatment was under fire for lacking in outcome research data and inconsistencies in practice. Not surprisingly, more and more young psychiatrists opted for training in biological psychiatry, seeing themselves finally as "real doctors", using evidence-based somatic treatments for most psychiatric disorders. In the meantime, the patients probably had not changed that much, wanting "the talking cure", alone or with their medications. This opened the field for a new generation of psychologists with their "evidence-based" CBT. They were a welcome addition to traditional psychiatry and CBT, being a manualised, structured, short-term treatment. It became within a relatively short time span the mainstream psychotherapy in most mental health services. A decade and half later there are more and more "evidence-based" psychological therapies aside from CBT and specialised treatments for different disorders, like PTSD, OCD, early psychosis, and borderline personality disorder. Even psychodynamic therapy has seen a come-back. There is less stigma of seeking psychiatric or psychological treatment and the demand on our services is huge.

But what happened to the psychiatrist as a therapist? Are we content of being regular medical doctors without the time or opportunity to talk to our patients on a regular basis? Does that have anything to do with how difficult it seems to be here in Iceland to keep young psychiatrists interested in hospital work? Many of them leave the hospital or decrease their hospital time in favour of private practice. To quote a younger colleague: "I do not want to spend the rest of my l life as a prescriber for other professionals. It is just not satisfying". ■

# Questions about psychotherapy

**There are a lot of similarities among the Baltic and Nordic countries, yet there are a lot of differences, as well. As this issue of "Nordic Psychiatrist" is dedicated to psychotherapy it was interesting to have a short glimpse into specifics of every country: general rules that regulate psychotherapy, education of psychiatric residents in that field, current challenges. So, here you see short interviews with the persons who are experts in the field in each country. Hope, you will find it interesting.**

**Ramunė Mazaliauskienė**
MD, Lithuanian University of Health Sciences,
Psychiatric clinic

**THE QUESTIONS:**

1. What is the content and form of the psychotherapeutical training in your country? How long does it last?
2. Psychotherapeutic training during the psychiatric residency.
3. Are there ongoing debates or changes in this field?

## Kjersti Solberg Lyngstad — Norway

*Head of the Psychotherapy committee of the Norwegian Psychiatric Association.*

1,2 In Norway training in psychotherapy is a compulsory part of the psychiatrist training (during psychiatric residency).

The requirement is minimum 105 hours (weekly, minimum 3 years) of psychotherapy supervision. Two years (70 h) in psychodynamic informed psychotherapy and one year (35 h) in one of three methods (group psychotherapy, CBT or psychodynamic psychotherapy). The supervisors are experienced, especially authorised psychotherapy trained (by recognised training institutes) psychiatrists. In addition to the supervision there are mandatory theoretical courses in the three methods (over three semesters).

3. There is a strong agreement on the minimum requirement of 105 hours (weekly, minimum 3 years) of psychotherapy supervision. We have an ongoing debate about the more specific content: which methods should be mandatory supervision and for how long time/how many hours for each method? The trend is to make at least CBT as well as psychodynamic psychotherapy mandatory.

## Anne Kleinberg — Estonia

*Child and adolescent psychiatrist, child and adolescent psychoanalytical psychotherapist, family psychotherapist. Head of Children Mental Health Center of Tallinn Children Hospital. Child and adolescent psychiatry lecturer at Tartu University. Teacher of child and adolescent psychoanalytical therapy therapists.*

1. There are trainings organized by psychotherapy associations (for example CBT, family therapy, psychoanalytical psychotherapy for adults and children and adolescents) which duration is approximately 1 year general training and 3-4 years advanced training.
2. For psychiatry trainees there is 1 year training during third and fourth year of training - 90 hours divided between family therapy, psychoanalytical therapy and CBT.
3. Yes there are. Most heated debate has been about psychotherapy specialty regulation and about professions who can work as psychotherapists in medicine. Doctors and clinical psychologist are generally agreeing that their education can be basis to become psychotherapist in medicine. Psychotherapist as separated profession is not yet regulated, and debate is going on.

## René Sjælland — Denmark

*Head of clinic at the Psychiatric Centre of Amager, chairman of the Psychotherapeutic committee, specialist in CBT.*

The Danish training in psychotherapy is divided into three steps.

Step 1 – Basic training: This is a mandatory part of the Danish training program to become a specialist in psychiatry. It consists of 60 hours of theory, 60 hours of psychotherapy sessions and 60 hours of supervision. The trainee must attain knowledge within psychodynamic psychotherapy and CBT. It is supervised by authorised supervisors. A minimum of 10 sessions must be viewed via video-recorded sessions.

**Step 2** – Specialist training: This is minimum 2-year training within a specified therapeutic approach, e.g. either psychodynamic or CBT. It consists of 160 hours of theory, 130 hours of psychotherapy sessions and 105 hours of supervision. On top of this the trainee must carry out his/her own supervision (20 hours) of a trainee in the basic training program, attain feedback on therapeutic style/self-therapy (30 hours) and make an academic written assignment.

**Step 3** – Supervisor training: This can only be commenced after minimum 2 years of specialist experience. It consists of 40 hours of theory, 80 hours of supervision, 50 hours of supervised supervision, and an academic written assignment.

We changed the training curriculum in 2015 for all 3 steps and have planned to extend the specialist training (step 2) further in 2019. This is because the basic training program is shorter than recommended by UEMS. We did not change the basic training as there is not yet a formal requirement of a similar amount of time for psychopharmacology and psychopathology.

## Thorgunnur Arsaelsdottir — Iceland

*is an adult psychiatrist, working in the outpatient department of the University Hospital in Reykjavik, and is also a member of the adult ADHD team. She is currently the president of the Icelandic Psychiatric Association.*

1. In Iceland there is much interest in Cognitive Behavioral Therapy, and the University of Iceland offers on a regular basis a 1 or 2 year training program in CBT in collaboration with Oxford Cognitive Behavior center in the U.K.
2. Our residents receive training in CBT and in psychodynamic therapy. The CBT training is a two year program. It consists of one whole day of theory each year, then twice per month supervision and exercises. Each trainee must finish at least two treatment reports. The trainee can then have support from the hospital to take extra courses in the CBT training program at the University.

   The psychodynamic training is also a two year program with the goal that the trainee recognizes the basic concepts and will be able to utilize them in clinical work. It consists of two half days for theory each year and clinical supervision twice per month. Each trainee must finish and return at least two essays on the topic.
3. In the past fifteen years or so we have seen a huge wave of interest in Cognitive Therapy, and in the psychology department of the University it is the only form of psychotherapy that is promoted. Lately there has been growing interest in psychodynamic therapy among our residents and young psychiatrists, and now they have a possibility of taking a 3 year training program in individual psychodynamic psychotherapy, organized by Icelandic psychiatrists and psychologists in Reykjavik and Oslo. It consists of their own psychoanalysis, theory, and individual psychotherapy under supervision. Currently 6 young psychiatrists and residents are in this training program.

## Elmars Rancans — Latvia

*MD, PhD (Chair of the Department of psychiatry and narcology, Head of the Residency program in Psychiatry in Riga Stradins University, Latvia)*

It is much easier to describe it for the training of psychiatrists, than psychotherapists.

Psychiatric residency training in Latvia consists of 4 years, 44 months of training.

Psychotherapeutic training is scheduled in the 2nd year 3 months rotation/course – covering crisis interventions, supportive psychotherapy, basics of psychodynamic interpretation of psychiatric symptoms. Every week there are two 3 hour seminars/group discussions (24 hours all together) + daily practical work with patients in different departments, where they try to use knowledges learned

In the 4th year there is a 4 months rotation/course – teaching basics of CBT and short term psychodynamic psychotherapy. Every week there are two 3 hour seminars/group discussions (32 all together) + daily practical work with patients in different departments

Some basic principles and practical experience in group psychotherapy is learned during 2 - 4 week in Minnesota programme within 3 months rotation in the course of Addiction disorders.

Training in Psychotherapy is only regulated for doctors. Riga Stradins University is the only one offering residency in Psychotherapy, which consists of 4 years training. Following training and passing exam Latvian Association of Physicians issue official certificate with profession Psychotherapist. Training programme is mostly focused on psychodynamic approach. There are only 1-2 psychotherapists trained a year through this programme.

There are many other schools of Psychotherapy present in Latvia, but training is organised either by collaborators from abroad, or local trainers. Some of them are high standards like CBT (3 years for doctors and masters of psychology), some very questionable both by lengths and content. But none of them are certified by Latvian Association of Physicians and their status and possibilities to practice independently is not legally regulated.

As far as psychiatric residency is concerned there are no plans to restructure/change those two rotations.

## Darius Leskauskas — Lithuania

*Lithuanian University of Health Sciences*

1. Psychotherapy in Lithuania is available as post-graduate studies for physicians, psychologists, and sometimes for medical nurses and social workers. Education is performed by various psychotherapeutic societies and schools, and for that reason there are differences in the duration and content of the education. Three post-graduate psychotherapeutic programs (two in psychodynamic psychotherapy and one in cognitive behavioral therapy) are certified by the universities, enabling physicians or masters in psychology to work as psychotherapists, being accredited by the Ministry of Health. The duration of these studies is 3 years.
2. During the residency, psychotherapy is taught as a theoretical course, accepting residents with various types of psychotherapy, principles and indications of its use. Residents have a possibility to participate in parallel psychotherapeutic studies organised by one of the psychotherapeutic societies.
3. Presently, an umbrella organisation for psychotherapeutic associations is created in Lithuania. One of its tasks is to determine the requirements to the qualification of psychotherapists and study programs.

## Sami Pirkola — Finland

*PhD, is the professor of social psychiatry in The University of Tampere. He is a psychiatrist and a psychiatric epidemiologist by his scientific career. He has published international scientific papers from 1999 to date, and his major projects have been nationwide data collections regarding suicides, the prevalence of mental disorders, and the effectiveness of mental health services in Finland. He is currently the president of the Finnish Psychiatric Association.*

1. In Finland traditionally, psychotherapeutical training has been provided by privately organized therapeutic communities. The trainees have paid the training themselves, but have been licensed to act as private therapeutists thereafter. The whole process is in a transition phase at the moment, aiming at getting a better control of the quality and organizing the provision practices more flexible and responsive to the needs of the patients.

   The training has consisted of seminars, exams based on literature, supervised therapeutic work and own personal therapy. The training has usually lasted from 3 to 5 years, when performed as an attachment to regular daily work. There has been a growing variety of background theories and frames of references, from psychodynamic to CBT and family therapies - all of the major disciplines.
2. There have been efforts to add formal psychotherapeutical training to psychiatric residency training, but these have not yet become the state of the art, due to challenges in resourcing and formalities. Some universities (Turku and Oulu) have arrangements and possibilities to provide some kind of formal psychotherapeutic (integrated- or family therapy) training.
3. There are at the moment, due to a major health- and social care organizational reform in Finland. Psychotherapy is to become better available and include a wider variety of theories and techniques than before.

## Ullakarin Nyberg — Sweden

*MD, PhD.*
*Chairman of the Swedish Psychiatric Association.*

1. Psychotherapeutical training is different in different parts of Sweden. All psychiatry residents have compulsory psychotherapy training. Most of training is in behaviour therapy or CBT. Some residents study psychodynamic therapy. Training takes about 2 days/week during 3 or 4 semesters. This includes theory lessons, skills training, patient treatment and supervision.

3. Yes, since many years. Some debate about form: they think psychotherapy training takes disproportionally long time compared to other important areas for resident training (for example clinical practice, psychopharmacology, neuroscience). Some debate about content, since most psychotherapy courses do not include different forms of therapy, which is necessary from a clinical point of view.
   Another ongoing debate is whether the residents' psychotherapy patients should suffer for those with uncomplicated disorders without comorbidity (which in Sweden are treated by the GP's). Many residency directors agree that it should be more aligned if residents had to treat patients with a more complex psychopathology (the kind of patients that residents work with in everyday practice and for the rest of their careers.

# Motivational Interviewing: Improving your conversation skills

**Integrating General Aspects of professional conversations, non-verbal communication, motivational interviewing, clinical skills, interpersonal behaviour and unconscious feelings**

Darius Jokubonis *Lithuanian University of Health Sciences, Kaunas Centre of Addiction Disorders (Lithuania)*

Cornelis de Jong *Prof, Radboud University, NISPA (The Netherlands)*

**It is hard to imagine anyone giving best medical advice to a patient to push past the issue of low motivation to change and not find themselves in short-circuiting the "Yes, but" cycle. In any case, even when the patient is blatantly and factually incorrect, little gain will be achieved by a direct confrontation.**

**A non-confrontational approach** that would lead to the building of rapport and eventually to a relationship in which the patient seeks information from the clinician was a completely unplanned and unanticipated development. It originated initially from an inspiration which came from Dr. William R. Miller's own data, whereby he noted that accurate empathy is the therapist skill that best predicts patient reductions in alcohol use. Leaving on a sabbatical from the University of New Mexico, Dr. Miller started working in an alcoholism clinic in Norway lecturing on cognitive-behavioral treatment and teaching a group of Norwegian psychologists about reflective listening through role playing with patients and discussing challenging clinical situations. These experiences helped Miller conceptualise some clinical principles and decision rules. This is how "motivational interviewing" (MI) emerged.

Through clinical experience and empirical research, the fundamental principles and methodologies of MI have been applied and tested in various settings, and research findings have demonstrated its efficacy. As MI is now established as an evidence-based practice in the treatment of individuals with substance use disorders, its principles have been applied to a range of mental health and physical health issues like depression, anxiety, and eating disorders.

Motivational Interviewing focuses on exploring and resolving ambivalence and centres on motivational processes within the individual that facilitate change. The method differs from more "coercive" or externally-driven methods for motivating change as it does not impose change (that may be inconsistent with the person's own values,

Participants of the seminar on motivational interview with prof. Cornelis de Jong (Netherlands) in Mariu hospital, Lithuania

beliefs or wishes). It rather supports change in a manner congruent with the person's own values and concerns. It is "…a collaborative, person-centred form of guiding to elicit and strengthen motivation for change."

MI is more than the use of a set of technical interventions. It is characterised by a particular mindset or clinical "way of being" which is the context or interpersonal relationship within which the techniques are employed.

The overall mindset of MI has been described as collaborative, evocative, and honouring of patient autonomy.

**Collaborative**

MI rests on a cooperative and collaborative partnership between patient and clinician. Whereas the patient-centred clinical method is a broad approach to the consultation, MI addresses the specific situation in which patient behaviour change is needed. Instead of an uneven power relationship in which the expert clinician directs the passive patient in what to do, there is an active collaborative conversation and joint decision-making process. This is particularly vital in health behaviour change, because ultimately it is only the patient who can enact such change.

**Evocative**

Often health care seems to involve giving patients what they lack, be it medication, knowledge, insight, or skills. MI instead seeks to evoke from patients that which they already have, to activate their own motivation and resources for change. A patient may not be motivated to do what you want him or her to, but each person has personal goals, values, aspirations, and dreams. Part of the art of MI is connecting health behaviour change with what your patients care about,

with their own values and concerns. This can be done only by understanding patients' own perspectives, by evoking their own good reasons and arguments for change.

**Honouring patient autonomy**

MI also requires a certain degree of detachment from outcomes – not an absence of caring, but rather an acceptance that people can and do make choices about the course of their lives. Clinicians may inform, advise, even warn, but ultimately it is the patient who decides what to do. To recognise and honour this autonomy is also a key element in facilitating health behavior change. There is something in human nature that resists being coerced and told what to do. Ironically, it is acknowledging the other's right and freedom not to change that sometimes makes change possible.

Conversational skills are of the utmost importance in every encounter with a patient. In fact the conversation with a patient is the cornerstone of the treatment of patients with mental health problems and practicing MI. "Improving Your Conversation Skills" was the title of the workshop that took place in 2013 – part of continuous training program (2012-2016) for Lithuanian mental health clinicians, performed together with specialists in Addiction Medicine from Radboud University.

The skills for an optimal conversation with patients were divided in three domains: Non-Verbal Communication, Motivational Interviewing, Interpersonal Behaviour and Unconscious Feelings. In their training, the trainees focused on these domains by means of role-playing followed by positive feedback – learning by doing in a safe environment. The trainees were offered instruments to make observations of conversations in a structured way and from the perspective of each of these domains. All trainees were invited to write down in advance a case with a patient in whom they have the idea that they have to learn new skills to do it better. This is the basis for the training and each trainee can only get something out of the training if she or he puts something in it.

A cornerstone in the training was to act as therapist and to learn how it is to be the patient by means of role-playing. The format of the role-play was quite simple: every trainee had to present shortly his or her own case. In the role-play he or she had to play the role of the patient. Another trainee took the role as a therapist. Both expressed their conversational problems and formulated their goals they want to achieve. In the training we worked in subgroups of 6 or 7 trainees. In each subgroup we will focus on one of the three main domains: Motivational Interviewing (Janine de Jong), Non-Verbal Communication (Irene Dijkstra) and Interpersonal Behavior and Unconscious Feelings (Cornelis de Jong). During the training the groups changed between the trainers and all of the trainees presented the same case in the session with each of the trainers. The therapists were changing in each of the different sessions. The result was that every trainee got the input on his or her case from three points of perspective and from three different therapists. A written evaluation of the training was not done until most of the trainees had reached their goals in improving conversational skills. ■

**Quotes on motivational interviews**

"Motivational interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change"
***William R. Miller***

"People are the undisputed experts on themselves. No one has been with them longer, or knows them better than they do themselves. In MI, the helper is a companion who typically does less than half of the talking"
***William R. Miller***

"If you treat an individual as he is, he will stay as he is, but if you treat him as if he were what he ought to be and could be, he will become what he ought to be and could be"
***William R. Miller cites Johann Wolfgang von Goethe***

"A fool takes no pleasure in understanding, but only in expressing personal opinion." PROVERBS 18:2
***William R. Miller***

# Open dialogue

Ramunė Mazaliauskienė

**Ramunė Mazaliauskienė**
MD, Lithuanian University of Health Sciences, Psychiatric clinic

**Open dialogue (OD) was born at Keropudas hospital in Tornio, Finland (1984). The staff of the hospital felt dissatisfied as to how the admissions of mentally disordered persons were handled and started a new approach. Importantly, the decision-making process during the treatment became an open process – with everyone involved present in the decision making – patient, their families, significant others, and the staff. In their work they used the ideas of Yrjö Alanen, a prominent Finnish psychiatrist, who implemented a need-adapted approach.**

**In his approach both the ideas of psychodynamic treatment, and systemic family therapy were used. The purpose of the team in Keropudas hospital was to avoid hospitalization organising available resources, and they were a success. The method was dedicated and used for all treatment situations. It is a community-based treatment inviting everyone who is involved to take part in treatment planning. In the long-term perspective, this process influenced the whole help delivery system, and some organisational changes occurred.**

**"Open Dialogue,"** first described as such in 1995 (Aaltonen, Seikkula & Lehtinen, 2011; Seikkula et al., 1995). The main ideas and principles of this method were described in the article "The key elements of dialogic practice in Open Dialogue: fidelity criteria" by M. Olson, J. Seikkula and D. Ziedonis (2014). It took only some 20 years for the method to be spread in many countries, such as Germany, UK, Poland, USA, Scandinavian countries, Japan, and South America. Trainings in Open dialogue are ongoing in many countries, and it is becoming more and more popular between both mental health care specialists, and users organizations.

Today the scope of what is Open Dialogue has broadened:

- Dialogue in the treatment meetings
- Way of organising the whole treatment system
- Way of educating staff involved in the treatment
- Way to rethink own practice.

The author of this article is familiar with the ideas of OD since 1996 and the material from the meetings on OD and the article by Olson, Seikkula and Ziedonis mentioned above is used for this overview.

Jaakko Seikkula and the Finnish team proposed seven main principles of the Open Dialogue (1995):

1. Immediate help – looking at the situation from crisis perspective and taking care of the emotional and affective elements of it
2. Social network perspective. Social network is included in two types of polyphony – vertical and horizontal
3. Flexibility and mobility

4. Responsibility
5. Psychological continuity
6. Tolerance of uncertainty
7. Dialogism.

All these principles are important, but some of them are more important than others. Such are tolerance of uncertainty and dialogism. What does tolerance of uncertainty means in the context of Open dialogue? First of all we talk about setting a scene for a dialogue – a safe and respectful surroundings where everything can be said or expressed in another way openly. It is crucial to define everything open and to avoid any premature decisions about the treatment or other important issues.

When talking about dialogism it is important to mention that the purpose of the meetings is to promote the dialogue in the system, not the change in the patient or the family. The recommendation is to listen, not to interpret what people say. This supports creation of new words and new language for the experiences that still have no words or language. When we talk about Open Dialogue meetings we must understand that they include both dialogical and monological communication. The second one is necessary to make some planning, e.g. about the next meeting, etc. Monological communication is considered to be typical in institutional environment where the patient and the families meet with the expert utterances of the professionals working there, and the voices of these professionals are dominant in the meetings with the patient and their families.

All these elements are included into the Open Dialogue meetings. As Peter Rober (2005) writes there are two fundamental skills required for clinicians to do Dialogic Practice: the skill of responding and the skill of reflecting: responding to what is heard or seen in the meeting, and reflecting on own thoughts and feelings that arise during the process. For some professionals, especially trained in some other types of therapy such type of communicating can be a real challenge, but there are a lot of on-going training programs where these skills can be developed or enhance it.

The ideas of Open Dialogue are developed further into "Twelve key elements of fidelity to dialogic practice in open dialogue", as described in the above article by Olson, Seikkula and Ziedonis. These elements are:

1. Two or more therapists in the treatment meetings
2. Participation of the family and the network
3. Using open-ended questions
4. Responding to the patients utterances
5. Emphasizing the present moment
6. Eliciting multiple viewpoints
7. Using relational focus in dialogue
8. Responding to the problem discourse or behavior in a matter-of-fact style, being attentive to meanings
9. Emphasizing patients own words and stories, but not the symptoms
10. Conversations among professionals in the treatment meetings
11. Being transparent
12. Tolerating uncertainty.

In conclusion, Open Dialogue – a method developed in Finland – has spread in Scandinavian countries, later to gain an increasing interest among mental health specialists (among the users as well, but this is a different story!) in many different countries of the world. Projects are on-going in Baltic countries, the one described by Dr. Maris Taube is one. ■


The lecturers and organizers of the conference: Prof. Arùnas Germanavičius (the adviser of the Minister of Health on mental health issues); Prof. Niels Buus (University of Sidney, Australia); Prof. Ramunè Kalèdienè (Lithuanian Health Sciences University); Ass. Prof. Sandra Steingard (Vermont Medical College, USA), Ona Davidonienè (head of State Mental Health Centre at the Ministry of Health); Prof. Virginija Adomaitienè (Lithuanian Health Sciences University); Prof. Jaakko Seikkula (Jyväskylä University, Finland); Prof. Douglas Ziedonis (Department of Psychiatry, University of Massachusetts Medical School, Worcester, USA), Ramunè Mazaliauskienè (Lithuanian Health Sciences University).

**Quotes on dialogue and language**

"Truth is not born nor is it to be found inside the head of an individual person, it is born between people collectively searching for truth, in the process of their dialogic interaction"
***Michail Bakhtin***

"Words belong to nobody, and in themselves they evaluate nothing. But they can serve any speaker and be used for the most varied and directly contradictory evaluations on the part of the speakers"
***Michail Bakhtin***

"There cannot be greater rudeness than to interrupt another in the current of his discourse"
***John Locke***

"If you have nothing to say, say nothing"
***Mark Twain***

"Whereof one cannot speak, thereof one must be silent"
***Ludwig Wittgenstein***

"One of the most misleading representational techniques in our language is the use of the word 'I' "
***Ludwig Wittgenstein***

"A new word is like a fresh seed sown on the ground of the discussion"
***Ludwig Wittgenstein***

"The limits of my language means the limits of my world "
***Ludwig Wittgenstein***

# Open Dialogue in Latvia

Maris Taube, Douglas Ziedonis

**Latvia has recently seen the development of community-based care, which includes outpatient centres, day centers, and open psychiatric departments. Open Dialogue (OD) could add to such treatment and care model. Dr. Ziedonis from the Department of Psychiatry, University of Massachusetts Medical School, who had started the approbation of the OD approach together with his colleagues in the USA, introduced the approach to his Latvian colleagues and stakeholders. The material "The Key Elements of Dialogic Practice in Open Dialogue", translated into Latvian and publicly available on the web site of the University of Massachusetts Medical School.**

**In Latvia, a discussion** about OD took place involving the leading psychiatry stakeholders from psychiatric units, educators as well as representatives from the Non governmental organization (NGO). The next step was the conference "Open Dialogue for Open Psychiatry" which took place in Kaunas and was well organised by Lithuanian University of Health Sciences. This meeting showed how different and also in the same time similar we are in understanding of OD concept. It gives us chance to apply it in praxis, at least to some degree. A wider discussion on positive aspects and also problems for the use of OD in Latvia took place in Strenci Mental Hospital in 2016, supported by the Baltic-American Freedom Foundation grant for the project "Open Dialogue approach in psychiatric services". Psychiatrists, psychologists, nurses, NGO representatives, and other specialists from different psychiatric hospitals in Latvia participated. Lack of available resources limits the possibilities to develop OD approach, and there are problems for acute and home visits – patients with acute conditions are usually hospitalised in the departments of psychiatric hospitals.

Despite problems there are positive developments. Direct contact with the patient and emotional listening are values that have been at the core of Latvian psychiatry for a long time. Latvian psychiatrists have valued clinical assessment, listening to the patient and families as well as forming doctor-patient relationship in the treatment process. At times, they do not appreciate formal clinical pathways and diagnostic scales. Listening to the patient is a classical value, which goes hand in hand with OD. The Latvian psychiatric society is open to new ideas. Involvement of NGOs can be a challenge to psychiatrists but provides also a good opportunity for work. ■

**Dr. Maris Taube** (above)
Riga Center of Psychiatry and Narcology, Community Mental Health Center "Veldre", Riga, Department of Psychiatry and Narcology, Riga Stradins University

**Dr. Douglas Ziedonis**
Department of Psychiatry, University of Massachusetts Medical School, Worcester, USA

# We need to talk about harm

Jørgen Flor

We need to talk about the harmful effects of psychotherapy. We need to pay attention to the one tenth of patients that actually get worse during treatment. We've known it for decades. It might be old news to you as well. So, why do we not talk more about it? Inform our patients? Make the government implement patient safety measures? Do research on why it happens?

During my clinical education as a psychologist, virtually noone talked about the potential of us actually hurting our patients. It was six years discussing which therapy method to choose or how one could optimise the treatment. Then, almost by accident, I discovered a research field, which were not part of the curriculum. I decided to investigate this taboo topic. When I interviewed ten experienced clinicians as part of my master thesis, they provided me with some hints as to why this is. Some were actually ashamed about their own mistakes, attributing patient deterioration solely to their own actions. Others lived in denial, failing to give even one example of patients worsening. None could give a precise description of what a negative effect is. Cognitive fallacies make our clinical judgment a bad compass in discovering patient deterioration.

So, how do we proceed from this? First, we need knowledge, recognition and open discussions. As medical doctors, you have an advantage. Side effects are a familiar topic when prescribing medications. You have experience on informing patients about this, without inducing nocebo effects or undermining the intervention itself. We need your thoughts on how to do the same in mental health.

The field of medicine have come a long way since To Err is Human[1] . The wonderful, recent book by brain surgeon Henry Marsh[2] is one example to that. He found comfort in that human fallibility and cognitive errors are in fact unavoidable consequences of the human brain design. Even though Marsh's mistakes might be more violent and fatal than ours, his cure could (easily) be adopted by talking about harm. About how we miss crucial information that lead to patients dropping out, how we overlook important symptoms or even apply techniques and interventions directly harming our patients. The first step is to learn from this by openly discussing it with each other. It is long overdue that we make patient safety culture an integral part of outpatient work. ■

**Jørgen Flor**
Psychologist

[1] Donaldson, M. S., Corrigan, J. M., & Kohn, L. T. (Eds.). (2000). *To err is human: building a safer health system* (Vol. 6). National Academies Press.

[2] Marsh, H. (2014). *Do no harm: stories of life, death and brain surgery*. Hachette UK.

# Letters of therapy

**Svein Øverland**
Clinical psychologist,
St.Olav's hospital

## *ACT: a travel to the place that matters*

Svein Øverland

**Dear colleagues.**

Therapy can be described as a travel. As a therapist, I have found that finding a therapy that speaks to my heart and soul is also a travel.

I have been to San Francisco training Dialectical Behavioural Therapy (DBT) and to Manchester learning Metacognitive Therapy (MCT). As a young psychologist, I got my basic training in psychodynamic psychotherapy at Nic Waal's institute. And I have myself taught Aggression Replacement Therapy (ART) in Stavanger.

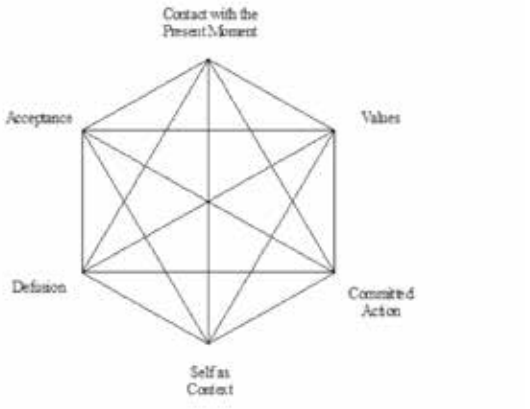
I find that all these "three-letter therapies" have given me skills to better help my patients. Despite different theoretical perspectives, they also have much in common. Sometimes it is even hard to understand the differences. I had for instance a lengthy discussion with professor Adrian Wells about the difference between MCT's "detached mindfulness" and DBT's "mindfulness". I still don't understand it.

ACT is a "third generation" CBT and shares as such many of the same features as DBT and MCT. But mostly, ACT is about values. And valued living. Most of my work with ACT is with patients with chronic pain. ACT teaches the patient to explore the pain and how to make a life without avoiding it. No matter what the patient's diagnosis or symptoms might be, the goal of ACT is to help the patient gain more psychological flexibility. Rather than being a victim of his symptoms, the patient finds a way towards the values and goals in life.

This might sound fluffy, but doing ACT consists of experiencing it yourself, rather than having it explained. The therapist shows the techniques in session and the patient commits to experiment with home assignments. ACT is a principle-driven therapy, with the Hexaflex being a road map of the process. Whether working with pain, depression or anxiety, the patient learns to act based on the answer to: "Will this leads me toward or away from my values?"

ACT is an evidence-based treatment for pain, depression, anxiety, and OCD (American Psychiatric Association, 2011 and the Australian Psychological Association, 2010). In the Nordic countries, the interest for ACT is particularly strong in Sweden (i.e. Strosahl, Robinson & Gustavson, 2014). ACT is also made available for the public through the Youtube videos of Russ Harris and popular mobile apps.

ACT is a playful therapy. It is also demanding for the therapist, as it requires discussing existential and philosophical issues. For training, please consult https://contextualscience.org ■



# *Anger management*

Elsa Bara Traustadottir

**Anger is an emotion** many people have a problem managing. It is a transdiagnostic problem seen in patients with severe psychiatric disorders such as paranoid schizophrenia and bipolar disorder, in personality disorders such as borderline personality, as well as in patients dealing with depression and anxiety, or people who do not necessarily meet criteria for any psychiatric diagnosis. Anger serves an important purpose to protect the person from any kind of threat. When we perceive a possible threat we react with anger (fight response) or fear (flight response) in order to protect ourselves from danger.

What we perceive as a threat has changed somewhat during human evolution from primarily being physical life-threatening situations to what is nowadays more common – threat of status such as lack of respect, insults, as well as threat to a persons family safety, financial security, personal health, general safety and well-being and whatever we find necessary to protect.

Anger is a valuable emotion and not in itself a mental problem. It can nevertheless become a problem when a person's reaction to anger leads to that persons or other peoples sufferings. This can happen in various ways. People may get angry often, stay angry for a long time, or become disproportionally angry. The person's behaviour may also be inappropriate and lead to family and social problems due to impulsive, aggressive or violent behaviour. This impacts on the person's quality of life in several ways, as well as on the quality of life of others.

Anger management refers to therapy aimed at helping the client managing his/hers reaction to anger. The therapy may be individual or group therapy and is commonly based on cognitive behaviour therapy (CBT) techniques, as described here.

An important element in anger management is conceptualising the problem. This involves identifying anger triggers, thoughts, feelings, physical reactions and behaviours as well as underlying beliefs and attitudes and assumptions towards self, others, anger and anger reactions.

Identifying one's own physical reactions to anger is an important element in therapy. Knowing these signs (heartbeat, physical heat, muscle tension, etc.) serves as an important warning sign that can give the client a valuable opportunity to choose appropriate reactions. One possible appropriate reaction may be time-out, a strategy where the person takes a temporary break (recommended at least for 60 minutes), calms down, and makes a strategy to solve the conflict.

**Elsa Bara Traustadottir**
Cand. psych. Clinical psychologist at the Forensic Psychiatric Unit at Landspitali University Hospital.

A few elements are necessary in a time-out: The person needs to tell their counterpart, without any aggression, that they wish to stop and will return to finish the conversation. During a time-out, one makes use of strategies to calm down, physical exercise, meditation or any mental distraction from the incident/trigger. Violent behaviour (screaming, kicking, or punching) should not take place during time-out, even if only aimed at material things, since it strengthens the relationship between anger and violence. (And the next time you get angry, a sand bag is rarely close by!).

When the client is calm, he may reevaluate the situation by correcting distorted thinking in order to solve the conflict. Traditional CBT work is of use here and many clients choose certain questions for this task such as; "Is my thinking helpful?" or "Are there otherperspectives?" Other important factors in anger management are problem solving techniques, goal setting and communication skills like assertiveness training and active listening. It depends on the case conceptualization what are the treatment goals and what skills are important to the client in order to manage his/her anger. ■

# *Basic Body Awareness Therapy (BBAT)*

Susan Christensen

**C is a 45 year old woman**, admitted to psychiatric hospital because of severe depression accompanied by many physical symptoms such as high muscular tension, pain and fatigue.

Assessment with BARS-MH shows imbalance in muscle tension, disturbed balance and coordination, and lack of bodily stability. Basic functions such as sleep, appetite, ability for physical activity, self-consciousness, and contact to others and reality are disturbed.

C is offered individual physiotherapy aiming at restoring basic bodily functioning, focusing on resources and healthy aspects. This includes Basic Body Awareness Therapy (BBAT) movements and massage, awareness training and reflection. The movements and massage helps C to get more in contact with bodily signals, helping her to get more conscious about her reactions. Through the treatment she is able to find a better physical balance, a more functional muscular tension balance, and it is possible for her to cope more adequate in difficult situations.

The physiotherapeutic BBAT approach is a movement awareness training program in which the person works with basic functions of movements related to posture, co-ordination, free breathing and awareness in order to reestablish the quality of movements in action, expression of the self, interaction with others and involvement in activities in life.

The movements are small and soft, meant to lead to a more functional and healthy movement pattern. Attention is guided towards both at doing and at what is experienced to stimulate mental presence and awareness. The movements are seen as therapeutic cornerstones supported by reflection and dialogue aiming at re-establishing new movement habits and ways of being.

Important theories in BBAT are: "The theory of the four dimensions of human existence", "The theory of the threefold contact problem", "Theories on encounter and motivation" and "Theories about movements and breathing". These theories clarify how movements, massage and awareness can help to restore balance freedom and the unity of body and mind.

The method was developed in cooperation between the French psychoanalyst and movement teacher Jacques Dropsy and the Swedish physiotherapist Ph.D. Gertrud Roxendal. The method stems from Western movement traditions, medicine, psychology and philosophy, and is also inspired of Eastern traditions such as Tai Chi and Zen meditation. In the last 30 years, further development has been initiated from the International Association of Teachers in Basic Body Awareness Therapy (IATBBAT).

**Susan Christensen**
Qualified in BBAT
Licensed teacher in BBAT, Clinic for Anorexia,
Mental Health Centre Copenhagen

The method has proven beneficial to persons suffering from longstanding multi-perspective musculoskeletal and mental health problems. Reliable and valid assessment tools have been developed, such as The Body Awareness rating Scale-Movement Harmony (BARS-MH) and the Body Awareness Scale-Movement Quality and Experience (BAS MQ-E)

BBAT is a postgraduate part time study program for physiotherapists. Education is offered by private institutes in some countries in cooperation with the physiotherapist unions. It is also offered at Bergen University College, Bergen, Norway, as a postgraduate study program in physiotherapy Basic Body Awareness Methodology (BBAM).

For further information see: www.IBK.nu, www.Nibk.org, www.bodyawareness.dk. ■

# *Compassion Focussed Therapy*

Sofia Viotti

**Compassion Focussed Therapy** (CFT) is an integrative therapy based on theory and research from evolutionary, developmental, social, and Buddhist psychology and neuroscience. In CFT, we help the client develop and strengthen physiological systems related to safety, soothing and connection, creating conditions for the client to deal with suffering and difficulties in life. Among other things we train the bodies soothing system through emotional, cognitive, behavioural, and physiological techniques.

CFT has been developed by psychologist Paul Gilbert with focus on clients high in shame and self-criticism – vulnerability factors in many psychiatric diagnoses. Gilbert noticed that some individuals after long time in therapy could understand things logically, but still suffered emotionally. They could see that there was nothing wrong with them and they could understand that people were not critical of them, but they still felt unsafe and experienced much shame. Gilbert noticed that these people had a cold, hard and critical voice directed against themselves. They also experienced caring attitudes from others or from themselves as being unpleasant.

Gilbert started to explore what caused this and how to help people develop an inner safety and caring attitude. He developed CFT with a focus of compassion. Compassion is a process where you are sensitive toward suffering in yourself or others, and have a commitment to try to alleviate it and prevent it. To be able to do that you need competencies like empathy, sympathy, distress tolerance, etc. In CFT, we help the clients to build these competencies.

The interventions used in CFT stems from CBT, PDT, Buddhist meditations and imagery methods. Only interventions based in research and proven experience are used. CFT is not a manual-based therapy, and interventions are chosen and modulated for the client from the case formulation and behavioural analysis.

I got my eyes on CFT during my studies to become a psychologist. I liked that it integrated many theories and methods and used what research showed from different areas. In the last couple of years I worked with CFT with self-critical clients, people with high demands on themselves and people with problems to feel calm and safe. I have also taught the method to therapists, health professionals, and people in other areas working with human behaviours. What I like with CFT is that it is a method we can use to understand life itself, not only mental illness. Therefore this method is helpful even as a way to work with yourself as a therapist, to use with workgroups and to look at general problems in our society. It helps us understand suffering, its causes, and what we can do to create a more human world.

If you want to learn more about CFT we are a couple of psychologists and psychotherapists in Sweden and the other Scandinavian countries that organise courses. You can also visit Derby and learn from Paul Gilbert himself. You find much information on CFT on my info webpage Compassionportalen.se ■

**Sofia Viotti**
Psychologist at Compassionfocus Sweden AB.

Sofia is the author of the book ”Compassion-fokuserad terapi” together with Christina Andersson. She is releasing a new book about CFT, stress and achievements during 2018. She has a Post Graduate Certificate in CFT from Derby University and runs the company Compassionfocus Sweden.

# *Dialectical Behaviour Therapy*

Lars Mehlum

**One of my patients** – let us call her Marianne – was referred to me after having had a series of suicide attempts and hospital admissions. She had already dropped out of treatment several times. Her life was full of crises and broken relationships and she was about to loose hope. I guess most of you have had similar patients.

There is a treatment designed to help people like Marianne. Dialectical Behaviour Therapy (DBT) – a principle-driven, multimodal treatment – that was originally developed by Linehan (1993) for patients with Borderline Personality Disorder and repetitive suicidal and non-suicidal self-harming behaviour. These patients are often regarded as difficult to treat effectively because of their unrelenting crises, tendency of seeing others in "black-and-white" terms, to burn out their therapists and to drop out from treatment.

DBT offers a wide range of strategies to deal with challenges such as these. One strategy is teaching patients skills in regulating emotions, strengthening distress tolerance and behaving more effectively in interpersonal relationships and solving problems. Patients are encouraged to contact their therapists between treatment sessions to receive coaching in how to effectively use skills instead of resorting to problem behaviours such as self-harm, substance abuse or engaging in other high risk behaviours. DBT adopts a behavioural approach to suicide and self-harm in order to identify antecedents and consequences, either causing or maintaining the self-destructive behaviours. Treating suicidal behaviours directly and specifically is regarded as essential. DBT offers multiple and specific strategies to manage suicidal crises and to prevent them from occurring. Numerous randomised trials have documented the efficacy of DBT to reduce suicidal behaviour and non-suicidal self-harm, decrease emergency room visits, psychiatric hospital days and a range of symptoms and behaviours causing poor quality of life.

However, it may surprise you to hear that the ultimate goal of DBT is not suicide prevention. DBT rather aims at helping patients get a life worth living through making significant changes in their lives. Making progress in treatment, creates a strong therapeutic relationship that balances the therapeutic strategies of validation and change.

**Lars Mehlum**
M.D. Ph.D.

If you would like to learn how to do this therapy, you should know that there exist systematic training programmes for DBT in Norway and Sweden, and some training activities in Finland and Denmark as well. ■

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# *Psychiatric Riding Therapy*

Kati Marjala & Pauliina Tuomivaara

**In Finland, training for riding** therapists (Equine Facilitated Therapist) is a 3-year further training programme for professionals. Trained riding therapists get a protected professional title (in Finnish "Ratsastusterapeutti-SRT"). A riding therapist can be a medical doctor, psychologist, nurse, occupational therapist, physiotherapist, or a social services professional. Each riding therapist gives therapy within the framework of their own profession.

Psychiatric riding therapy is widely implemented in Finland. In many of the hospital districts, riding therapy is bought as a service from the private sector. In addition to Helsinki and Uusimaa hospital district and City of Oulu mental health services, numerous government-owned educational establishments have their own riding therapist and/or their own horses that are used in rehabilitating clients. Social services also buys riding therapy for its clients. Riding therapy can be carried out individually, for groups and for families. The methods used include grooming, tacking up, feeding, stable work, riding, leading exercises, carriage driving, skijoring with a horse, observing herd behaviour, photography, and discussions.

Riding therapy is especially beneficial when the patient has suffered a psychological or physical trauma and has trouble trusting other people. The patient does not have to have previous experience of horses or riding – not having it might even be an advantage. Riding therapy is used as treatment and as a form of rehabilitation for depression, anxiety and communication disorders, neuropsychiatric disorders, psychosomatic conditions, eating disorders and other body image issues, as well as the psychosocial crises at different stages of life. Some international research has already been done. Pendry (2014) et al. at the University of Washington studied the effects of equine-assisted activities on the cortisol levels of children and adolescents. Human-animal interaction, petting and touching, increases the production of oxytocin, which in turn lowers the cortisol level in the body. The rhythmic movement of the horse helps the patient to start becoming more aware of their body and the different sensations in it. Rhythm and movement also help organising thoughts and words. Horses have a natural ability to mirror human body language, emotions and interactions, and through this, the patient can observe their own behaviour and develop methods to control it. The purpose of this physical approach is not only to ease symptoms or for example deal with past trauma: it can also be to rebuild the patient's self-concept.

Physical contact with the horse and its movement, especially trot and canter, awakens the body's natural energy reserves. Movement also increases activity in the mind. Riding on the back of a walking horse is reminiscent of being in held in mother's arms. This physical memory may help the patient to access memories and interactions from a very early age.

Horses are big and impressive animals. Being prey animals, they react to our deepest emotions and inner conflicts, no matter what we pretend on the outside. This reaction is a therapeutic element and a useful tool when working with for example personality or conduct disorders. Feedback from an honest animal is easier to accept and process than verbal feedback from a therapist. Working with a horse enables patients to recognise their own emotions, to define how close people or things can come, and to establish their personal boundaries.

Therapy patients commonly notice what horse people also know: being with horses takes away tiredness and gives more energy. Horses live in the moment. Focusing on the here and now lets the mind rest and is a very effective therapeutic element in the treatment and rehabilitation of a patient who's traumatised or even has psychotic symptoms.

The methods of treatment and rehabilitation are very similar for both adults and children, but with children, activity, games and play are given a slightly bigger role. A child with psychiatric symptoms needs a safe environment and boundaries, help with putting emotions into words and a feeling of control over their own body. The rules and structure at the stable and the boundaries set by the horse can help to calm a restless mind. The wordless interaction between the child and the horse opens a way for the therapist into the patient's mind, and this enables the therapist to help and put into words the feelings that the child has no words for. An example: if a child grooming the horse is fidgety and rough, the horse starts to get fidgety as well.

Horse is a noble and powerful animal, but a therapy horse is also reliable and safe. Controlling

**Kati Marjala.** Photo by: Kimmo Pentti.

**Kati Marjala**
Psychiatric nurse, Equine facilitated therapist/
Ratsastusterapeutti-SRT

**Pauliina Tuomivaara**
Equine facilitated therapist/
Ratsastusterapeutti-SRT.

**Pauliina Tuomivaara.**
Photo by: mainostoimisto Jäljen Jättiläinen

a horse requires willpower, which patients at the start of therapy do not always have. Controlling a large animal by leading or riding it is a feat, and an empowering experience for anyone.

#### Case example

Psychiatric riding therapy was used in conjunction with stabilising trauma treatment. Therapy was carried out in 2014, 11 sessions lasting 1 – 1.5 hours. Patient was a 32-year-old woman, diagnosis F43.1, F33.2 (ICD-10). During the first sessions, the focus was on the patient's perception of her own body and the surroundings. Then the focus shifted to strengthening the posture and muscle tone with the help of leading exercises, at the same time practicing how to protect personal space and to strengthen boundaries. It is also important to be able to move away from the self and focus on the surroundings and the moment.

Throughout the riding therapy period, changes in the patient's alertness were clearly visible. She arrived listless and passive, but after the session she was more alert and energised. At the beginning, the patient got tired after a session and went to bed as soon as she got home. After the fourth session she got over-excited, which made her overly active at home. Towards the end of the period, the level of alertness started to remain stable. The patient was calm and relaxed after a session and was able to do normal household chores for a while.

According to her personal nurse at the mental health clinic, something that happened during a leading exercise in the third therapy session activated and brought to the surface a memory of trauma, which could then be addressed in stabilising trauma treatment. Functional exercises and the activation of body with the horse helped the treatment of trauma in discussion therapy. At first, the patient's ability to perform exercises in stabilising trauma treatment was poor, but after the riding therapy started, work on the dissociative parts of personality and regulating alertness levels got better.

Patient highlighted three things in her feedback about the therapy: staying in the moment, trust, and personal space. She had learnt to trust herself more and to trust the horse. Personal space was an important issue for her and she realized new things about it. Previously she had not thought that she could stand up for herself and protect her personal space. ■

*More on the subject in: Mattila-Rautiainen S. (ed.) Ratsastusterapia. Bookwell Oy. Juva. 2011. Parts of the book will be translated into English and published in 2017.*

# *Group psychotherapy*

Synnøve Ness Bjerke

**Challenged to write about my favorite activity** as a therapist, group psychotherapy, I will start with stating a simple fact surprisingly poorly known: Group psychotherapy is a very efficient type of therapy for most psychiatric and substance abuse related problems, equivalent to individual therapy. This is shown in research over decades. For some diagnoses the best result comes when group psychotherapy is combined with individual therapy, this applies for instance to the treatment of borderline personality disorder. For many conditions, short-term group psychotherapy (18-20 meetings) can be sufficient. For more complex and relational problems, more time is needed for a lasting change to be achieved.

There seems to be a certain hurdle to join group psychotherapy, not only for patients, but for therapists as well. It easily brings fantasies of being overwhelmed. To understand all its richness and all its potential benefits, one needs to experience it or to learn about it from someone with much experience in the field. Often the most skeptical patient ends up being the one who benefits the most. To learn to speak one's mind, share painful experiences, reflect on difficult feelings and thoughts together with others, in similar but not identical situations, gives both hope and new perspectives. Patients' resources are activated. One learns to identify patterns of communication or non-communication, which causes problems and one can practice – with support – new ways of handling similar problems. Belonging to and receiving support from a good group is a healing situation in itself. Most patients who have attended group psychotherapy strongly recommend it to others!

There are many different ways of conducting group psychotherapy. Cognitive therapy in groups can for instance take the form of individual therapy in a group setting. It shows good results, but does not necessarily use all possible advantages of the group setting. This is probably mainly because cognitive therapists do not have a group theory, nor are they usually trained as group psychotherapists. This is not intended as a complaint, just to say there is more to the format to benefit from, if one is interested to learn, than simply "saving time and resources" by seeing more people at the same time in a group.

When I talk about group psychotherapy here, I lean – as most European trained group psychotherapists – on the theory of group analysis. Group analysis developed and applied is close to what the Americans call psychodynamic group psychotherapy. It is based on the use of known psychodynamic therapeutic factors, and also on the use of several specific group psychotherapeutic factors. The most studied and best documented is group cohesion, followed by instillation of hope, not feeling alone, interpersonal learning, honest feedback, and helping each other.

**Synnøve Ness Bjerke**
MD, Group Analyst
IGA, institute for group analysis

It takes training to facilitate and help the group build a safe enough group climate to open up to each other and make full use of the group. It also takes training to spot potential destructive processes in the bud, work with them for mutual benefit and thereby prevent destructive group processes like scapegoating.

In Norway, Institut for gruppeanalyse og gruppepsykoterapi (IGA/www.iga.no) in Oslo, trains in a block program close to 100 candidates each year. Full group analytic training takes 4-5 years, depending on initial education and skills. A qualifying group psychotherapy training program takes 2-3 years. In Denmark there are similar institutes both in Copenhagen and Aarhus. We welcome candidates from other Nordic countries who speak a Nordic language. At the time being we have candidates from Iceland and Sweden. ■

# *Illness management and recovery (IMR)*

Kristin Heiervang

**Illness management and recovery** (IMR) is a standardised psychosocial intervention designed to help people with serious mental illnesses to manage their illness and achieve personal goals. The most important message of this program is hope, and to experience that recovery is possible and that expectations of a fulfilling and meaningful life are legitimate.

IMR has a strong empirical foundation in illness self-management and recovery, and is based on the stress-vulnerability model. The aim is to learn to know yourself, your strengths and weaknesses, your hopes and dreams, to seek support and give it to others, to continue the learning of relevant knowledge and skills and to use these in the pursuit of meaning, and personal growth.

IMR was developed in USA during the National Implementing Evidence-Based Practices (NIEBP) project and has been implemented throughout Scandinavia since then. In Norway, it has gained new interest as a tool in medication-free treatment, even though medication is one of the eleven themes covered by the programme. The strategies forming the basis of the IMR programme are: psychoeducation to improve knowledge of mental illness, relapse prevention to reduce relapses and rehospitalisation, behavioural training to improve medication use, coping skills training to reduce the severity and distress of persistent symptoms, and social training to strengthen social support. These strategies are taught through a combination of educational, motivational, and cognitive-behavioural techniques. In addition, there is a strong emphasis on personal recovery and what that means to the individual. IMR is organized into 11 modules with different topics covering different aspects of life. A workbook with educational hand-outs is taught weekly to service users individually or in groups, for 10 - 12 months.

Even though a major part of the course is devoted to the comprehensive psycho-educative curriculum, it is equally important to expand self-respect and respect towards others, to engage in other group member's journeys, to share experiences of life and mental illness and to give each other encouraging feedback and mutual support. The personal goals expands from being able to participate in the group, to find a job, getting a new apartment, staying away from drugs and alcohol, getting in touch with old friends, or reconnecting with family members.

Five recovery processes have been identified and are encouraged by the IMR-program comprising: connectedness (to the therapist, group members and significant others in each person's social network); hope and optimism about the future; identity (to identify your identity independently of your mental illness); meaning in life (expressing and realising what is important to you in life, what is meaningful to you); and empowerment (how you can use your skills, personal strengths and talents to become more empowered, giving the acronym CHIME by Leamy et al., 2011).

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Researcher, Psychologist, PhD

You learn the skill to do this therapy by attending 2-4 days of training, depending on previous level of experience in CBT, MI, and group interventions. Training gives an initial theoretical framework with emphasis on recovery and focuses on practical aspects of delivering the programme as materials and manuals, the group format, teaching and therapeutic principles. In addition, 35-50 group supervision sessions for 12 months or more commence after training.

In Norway IMR is included in a nationwide implementation package and a national network for IMR has been established (IMR-Norge). We are currently working towards an international consensus regarding certification of IMR initiated by Sweden, where IMR is included in national guidelines for psychosocial treatments for schizophrenia. ■

# *Existential Therapy*

Rimantas Kočiūnas

**Existential therapy** is a comparatively young but actively growing paradigms of psychotherapy. It emerged in the third decade of the 20th century as an attempt to reflect on the principles of psychoanalysis in the new light of philosophical anthropology, first of all, of the fundamental work by Martin Heidegger "Being and Time" (1927). Now existential therapy is a rather diverse school with several dominant theories, most prominently Dasein analysis (Ludwig Binswanger, Medard Boss, Alice Holzhey-Kunz), logotherapy (Viktor Frankl, Alfried Längle), American humanistic-existential psychotherapy (Rollo May, James Bugental, Kirk Schneider), British existential analysis (Emmy van Deurzen), and existential phenomenological therapy (Ernesto Spinelli).

From the very beginning, the practice of existential therapy has been closely related to philosophy, since it is based not on some psychological theory of personality, but on philosophical understanding of man. A human being is understood not so much as a combination of relatively stable mental processes, intrapsychic structures and qualities, but as a being-in-the-world (Dasein, using Heidegger's term) that is ever becoming, changing, developing, as a process of life evolving in indefinitely variable contexts, which is finite timewise and comprising the self and the world as indivisible wholeness.

Existential therapy employs the phenomenological method as a foundation of its work, and this defines the position of the therapist in the process of therapy – the therapist is to apply phenomenological reduction, which means restraining one's inner attitudes and beliefs, theoretical background and worldview with the goal to be able to explore and describe the client's experience without any bias. The therapist maintains an "un-knowing" position, avoids attempts to explain anything and strives to view all aspects of the client's experience as potentially significant for his/her understanding.

Existential therapy aims to explore how each unique person creates his/her individual ways of life, what possibilities he/she can see and which of them chooses, how he/she relates to limits and boundaries imposed by nature or life situations. One important aspect to be explored is the client's relation to existential "givens", universal features of human existence (finiteness of life, historicity of being, relatedness to other people and most diverse contexts of existence, inevitability of choice, conditions of freedom and responsibility, anxiety as inherent modus of human existence, striving to find meaning in one's experience). The process of therapy is based on building and continuous exploration of dialogical therapeutic relations which allow insights into reflections of the client's difficulties. The process of existential therapy is focused on the client's present, while his/her past and future are considered an important and integral part of this present.

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Existential therapists do not apply any special "existential" methods or techniques, they only use universal therapeutic skills (listening, questioning, reflection of feelings and content, etc.). It is essential that therapeutic work helps to better "illuminate" the client's life story or his/her existence at that moment in life.

Thus, existential therapy appears to be a unique combination of philosophical world view, the therapist's phenomenological stance and his focus on present experiences and therapeutic relations. It seeks to help the client to explore and understand his/her difficulties, to become more genuinely aware of them, to view his/her daily life and its perspectives more realistically, to choose more productive ways of life and accept responsibility for these choices.

In Lithuania, since 1996, the Institute of Humanistic and Existential Psychology (www.hepi.lt) offers training in existential therapy. In 2015, the training programme, as well as the Institute itself, was accredited by the European Association of Psychotherapy. In 2000, the East European Association for Existential Therapy was founded and registered in Lithuania; at present it has over 300 members from Lithuania, Latvia, Estonia, Russia, Belarus, Ukraine, and other countries. ■

# *Internet-delivered computer-assisted psychotherapies deliver low-threshold support in Finland*

Jan-Henry Stenberg  Matti Holi

**Use of Internet-based services increase** in all areas of life. Recent technological advances in the use of internet and computer-assisted technologies have impacted on the provision of psychotherapy and other psychological services. When utilised appropriately these innovative practices may provide greater access to needed services including treatment, consultation, supervision, and training. In Finland, Mental Hub (mielenterveystalo.fi) is a low-threshold online therapy programme that gives information, support and treatment on mental health and psychological wellbeing. The service provides for children, teens and adults a support that is tailored especially for their needs. Mental Hub is a comprehensive, government-sponsored, modular nationwide Internet portal for mental health and substance use disorder care services.

Mental Hub provides reliable information and support for all citizens including mental health patients, their families and friends as well as professionals seeking further information. These services are developed by health professionals, so they are a more reliable source than online search engines.

Users are guided to the right services based on the location where they live and their severity of distress using an innovative "symptom navigator" with concrete contact data, driving instruction and maps.

Anyone can face a situation in life where they or someone close to them needs support for their mental well-being. In Finland, approximately 20 per cent of people suffer from some mental health deviation during their life. Mental Hub's aim is to attract a million Finnish users.

The service provides support in assessing the severity of symptoms and can propose suitable service providers for further help. With a doctor's referral, Mental Hub provides computer assisted therapies over the internet.

Therapy sessions of iCBT provided by HUS (The Hospital District of Helsinki and Uusimaa) represent best practice principles used in CBT programs for depression and anxiety programs including behavioural activation, cognitive restructuring, and problem solving, setting goals and challenging inner beliefs. Part of the content of each therapy sessions is presented in the form of different illustrated stories about three patients who are using online therapy and gaining mastery over their symptoms.

The HUS iCBT program consists of similar treatment structures and methods as used in conventional standardized CBT, divided in 7 steps or therapy sessions. Between sessions patients are given homework assignments. The iCBT contains video, audio and text contents, as well as exercises of written and behavioural forms, such as thought and behaviour recording. Automatic e-mails are sent to congratulate participants for completing sessions and to remind them to complete materials and to inform them of new resources. The guiding therapist will also give written summaries two times during the therapy. Participants are expected to do the homework tasks prior to complete the next session. Duration of therapy is 2-3 months, but participants can still use the program and its works for up to a one year period. ■


**Jan-Henry Stenberg**
PhD
**Matti Holi**
MD, Adjunctive professor

# *Mentalisation-based treatment*

Sigmund Karterud

**Mentalisation-based treatment** (MBT) was originally tailored for borderline personality disorder. The application is now wider, but the "classical" MBT format is still that of long term (1.5 – 3 years) intensive outpatient treatment, which includes psycho-education and individual and group psychotherapy. It can be supplemented by MBT milieu therapy and/or MBT family therapy. Since it addresses severe personality pathology, it is anchored as a team project. Several and different therapists from diverse professional backgrounds learn to cooperate. It is particularly helpful that an essential component of this team approach is video-based group supervision.

Borderline patients were in older days considered to be very difficult to treat, they engendered pessimism, they used to drop out of treatment, and they were said to "split" the staff into naïve supporters and cynical rejecters. The therapeutic atmosphere around these patients have radically changed due to developments in personality theory, in particular with regard to borderline psychopathology, a firm therapeutic structure, treatment manuals, and a transparent cooperative team approach where different therapist share their practical work. We recently published a study from Oslo University Hospital (Kvarstein et al., 2014), demonstrating that modern borderline treatment can achieve a low 5% dropout rate and very high effect sizes (magnitude 1 – 1.7) on crucial outcome measures. The atmosphere now should be one of optimism.

There are abundant MBT training courses available in the Scandinavian countries. In Norway around 1400 professionals have attended the MBT introductory course and 200-300 have attended the one year advanced course (in individual or group MBT). The advanced courses are organised around the manuals and the participants have to present videotaped recordings of their therapies. The training is focused upon therapeutic skills.

During advanced training, the candidates present widely different patients, attesting to the wide diversity of the label "borderline" both with respect to personality profiles and level of personality functioning. This is optimal for training purposes. Personality profiles can be analysed and contrasted, and candidates learn differences between low and high mentalising capacities and their therapeutic implications. We always have candidates struggling with the most severe patients that have been repeatedly hospitalised, often borderline psychotic, being horrendously self-destructive and who have become cases for psychiatric polypharmacy and security measures, more than cases for psychotherapy.

**Sigmund Karterud**
MD, PhD

It is a privilege when we as trainers can witness how these individuals at the brink of human existence gradually transform into responsible social agents in a psychotherapeutic project that manages to restore their sense of self, affect regulation, and reflective functioning.

***Information about the author***

Sigmund Karterud is professor of psychiatry, formerly at University of Oslo and Oslo University Hospital. His most recent textbook is "Personality Psychiatry" (with Theresa Wilberg and Øyvind Urnes). In a forthcoming book ("Personality", Gyldendal 2017) he outlines a modern theory of personality founded upon temperament, attachment and mentalising. He is currently head of the Norwegian Institute for Mentalising and directs most of MBT training in Norway, in cooperation with professor Finn Skårderud. ■

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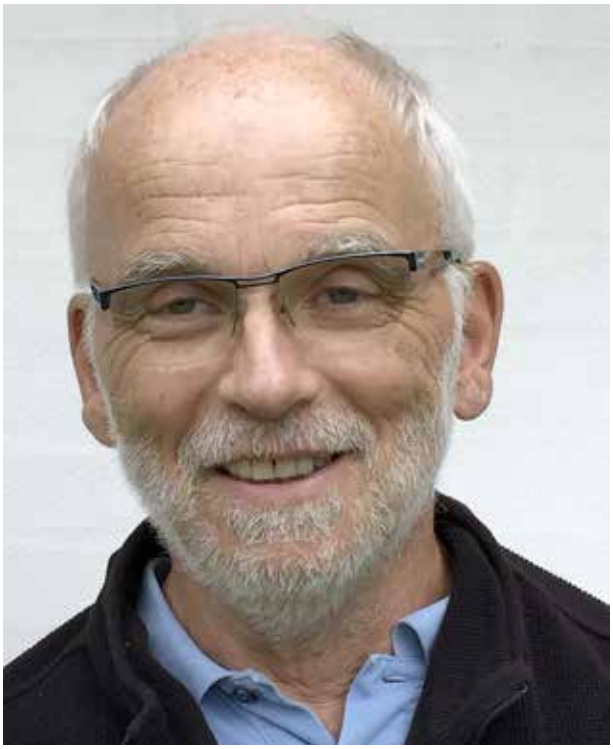
# *Psychoanalytic psychotherapy*

Sverre Varvin

**Psychoanalytic psychotherapy carries** a long tradition, stemming back to Freud. Since Freud's time, there have been important developments and significant changes in the psychoanalytic understanding of the human psyche and how people change during development and, consequently, in the psychoanalytic method and its use. I here mention psychoanalytic therapies in plural. These are psychotherapies with different lengths (from less than 20 sessions to hundreds) and with different frequencies adjusted to the patient's needs and problems.

Psychoanalytic psychotherapy is comprehensive and aims at helping the patient with underlying problems – problems that produces suffering in daily life. The focus is on how persons relate to others, which of course is determined by relational experiences from birth onwards. A main idea is that problems and conflicts will appear in the therapeutic relationship, in the transference, and that important information on what the patient struggles with can be achieved when the therapist also focuses on own reactions, feelings and fantasies, the countertransference, when he or she is with the patient.

*A woman in her thirties came to me for therapy, because, as she said "it is so difficult with other people", especially her boyfriend at the time. She reported a fairly good childhood, except for her parents' divorce when she was 7 years old. I noticed quite early in the sessions that was quite anxious and "on guard". She came reluctantly into my office, looked carefully around and sat always with her bag tight on her lap. In some sessions, she was a bit confused. In one session, she suddenly panicked. She started frenetically to seek in her bag. I inquired carefully what was the matter and she said, crying, that she had forgot her knife. I became quite surprised. After a while she could tell me why she needed her knife. She was quite sure that at some point I would get "power over her" and then she had to do exactly as I wanted. Then the important background for her coming to therapy appeared. She had been abused by a teacher at her school when she was 8 to12 years old and had not, under serious threats from the teacher, been able to tell anybody. This was the starting point for a process where she, and I, could work with this terrible experience. A process lasting for more than a year, but which in the end made her feel much safer in life in general and also in close relationships.*



**Sverre Varvin**
MD, PhD, Psychiatrist and Professor

Work with her experiences in an increasingly trustful relationship gradually changed her underlying insecure relationship models and, as I later learned, made it possible for her to stay in an intimate relationship with the person she loved. ■

# *Mindfulness in Lithuania: Gaining momentum*

Julius Neverauskas  Giedrė Žalytė

**The origins**

Mindfulness is a word known in a wide variety of settings. Respected and trusted by many and frown upon by some, this meditative practice has its roots in the Buddhist tradition and was introduced into the Western medicine and psychology by the American biologist Jon Kabat-Zinn in the late 1970's. His definition of mindfulness *as a practice of non-judgementally and purposefully paying attention to whatever is happening in the present moment continues* to be widely used. Jon Kabat-Zinn secularised the practice, created a structured programme for teaching it and gave it the name of Mindfulness-Based Stress Reduction (MBSR). This 8-week programme has been widely researched and found to be effective for a variety of conditions including chronic pain (John Kabat-Zinn's original target), anxiety disorders and depression. It has also been found to improve psychological health and quality of life in cancer patients and has been widely used in this area.

**Further developments**

Other structured mindfulness-based interventions were developed in the 1990's and early 2000's and include Mindfulness Based Cognitive Therapy (MBCT; originally developed as a preventative tool for recurrent depression), Mindfulness-Based Relapse Prevention (MBRP; developed for treating substance abuse) and Mindfulness-Based Eating Awareness Training (MB-EAT; developed for treating obesity and binge eating).

Mindfulness practice has also become an important component of other modern psychological interventions known as Third-Wave Cognitive Behavioural Therapy, such as Dialectical Behavior Therapy (DBT; originally developed as a treatment for Borderline Personality Disorder) and Acceptance and Commitment Therapy (ACT). These interventions stress the need to practice acceptance of the aspects of our experience that cannot be changed, while at the same time working on changes in areas where change is possible. In particular, DBT and ACT stress the need to accept negative emotions as a part of life. Mindfulness practice, which teaches us to observe our own experience in a friendly, non-judgemental manner, can be a powerful tool in changing our relationship with negative emotions thereby enabling us to make wiser choices in challenging situations. As a result, mindfulness practice has attracted interest from non-clinical settings and have been implemented in organisations such as the U.S. Army, Google, General Mills, and many others. Mindfulness is also practised at schools and other educational institutions. It has even been introduced to the British Parliament, and about 10% of the British MPs have graduated from an 8-week mindfulness course.

**The practice that changes the brain**

Research has shown that 8 weeks of regular practice, as taught in MBSR and MBCT, has the potential to physically alter the brain of the practitioner: it increases the activity of dorsolateral prefrontal cortex which is responsible for attention and decision-making; it also increases the activity of insula which plays a role in our sense of self and is important for the feeling of empathy. In addition, it alters the activity in brain stem where noradrenaline and serotonin are released. Furthermore, research

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**Giedrė Žalytė**
is a psychologist and a CBT therapist. She graduated from a 3-year CBT training course held by the Lithuanian CBT Association in 2010 and has been practicing CBT since. She is a certified MBSR and MBCT teacher (Institute of Mindfulness-Based Approaches, 2012) and a holder of an MSc in Psychological Therapy in Primary Care from the Universities of Dundee and Stirling, UK (2016). Her current activities comprise clinical practice and teaching.

has shown that 8 weeks of regular practice is sufficient to decrease the density in the grey matter of amygdala, which plays a key role in stress response and determines levels of anxiety.

### Learning by practising

From the very start, it has been stressed by Jon Kabat-Zinn and that mindfulness is *a practice*, which can only be learned by engaging in it on a regular basis. Just as our muscles cannot get stronger by us reading about physical exercise, the "mindfulness muscle" cannot be developed without regular mental exercise. Therefore, the core of mindfulness-based programmes (MBSR, MBCT, MBRP and MB-EAT) consists of mental exercises that participants are introduced to in weekly group sessions, and which they need to practice at home on a daily basis. Professionals delivering these programmes are also required to have their own personal mindfulness practice. The idea is that the professional teaches through his or her own *embodiment* of the core concepts behind the approach, which can only be sustained by regular practice.

### CBT and mindfulness-based interventions in Lithuania

Mindfulness-based interventions have been introduced in Lithuania by practitioners of Cognitive Behavioural Therapies (CBT) as an evidence-based alternative to the classical CBT, which has been taught in our country since 2007. Initially, the CBT training programme was managed by the Lithuanian CBT Association, and since 2014, a 3-year postgraduate training programme

in CBT has been taught at the Lithuanian University of Health Sciences. At the moment, 128 professionals (medical doctors and psychologists) are enrolled in the programme, while another 58 have already graduated from it.

In 2016, the Lithuanian University of Health Sciences also introduced a one-year postgraduate training programme in MBCT. A first cohort of 65 professionals graduated in January 2017 and started introducing mindfulness-based interventions into their clinical practice. A new cohort of another 48 professionals has just started their training. These are high numbers for a country with the population of only 3 million people, indicating that the interest for evidence-based psychological treatments such as CBT and mindfulness-based interventions is growing and catching up with the rest of the Western world.

**Mindfulness in clinical practice and beyond**

In Lithuania, mindfulness-based interventions are delivered both in the structured, original format as a single intervention (mostly MBSR and MBCT) and in combination with other therapeutic interventions, especially CBT. CBT therapists often employ mindfulness exercises to teach their clients to better regulate difficult emotions. For example, mindful breathing (during which the attention is focused on physical sensations of breath and is repeatedly brought back to these sensations) is often used as a way to refocus attention and refrain from immediate and unhelpful reactions to negative experiences. The Three-Minute Breathing Space, one of the hallmarks of MBCT, can often be used to pause and re-open our eyes to the present moment reality. For clinicians with a CBT background, mindfulness exercises is a  welcome alternative to working on cognitive distortions in more direct ways, such as thought records or behavioural experiments.

Through non-reactive observation of internal and external events, clients learn to see reality with fewer distortions, which is a goal of any psychotherapy. This can be especially helpful in complex cases such as personality disorders, where methods aiming to change thoughts or beliefs directly might not work. There is also a rapidly growing interest for mindfulness-based interventions for children, both in clinical and educational settings.  In parallell, businesses in Lithuania have also started introducing mindfulness practice to their employees, with Ikea being one of the pioneers in the field. In other words, there is a widespread and growing interest for this promissing practice. ■

**Quotes on mindfulness**

"If you want to conquer the anxiety of life, live in the moment, live in the breath "
***Amit Ray***

"If someone comes along and shoots an arrow into your heart, it's fruitless to stand there and yell at the person. It would be much better to turn your attention to the fact that there's an arrow in your heart... "
***Pema Chödrön***

"In the end, just three things matter:
How well we have lived
How well we have loved
How well we have learned to let go"
***Jack Kornfield***

# *Solution-focused therapy*

Ben Furman

Solution-focused Therapy (SFT) is a brief therapy model that was developed during the 80's at Brief Family Therapy Center in Milwaukee USA by a team of therapists lead by Insoo Kim Berg and Steve De Shazer. It is a modification of the brief therapy model that was developed at Mental Research Institute during the 70's, which in turn was based on the innovative therapeutic ideas by the late American psychiatrist Milton H. Erickson.

SFT is based on a few simple basic assumptions. Firstly, it is assumed that clients are better at finding solutions to their problems than they think they are. This philosophy is epitomized by an adage that was characteristic of Erickson's work. He used to say "The patient knows the solution to his problem. He only doesn't know that he knows it." Thus, the goal of the SFT therapist is to interview the patient in way that empowers the client to find his own solutions.

The focus on SFT is not problems but goals; not what the client wants to get rid of, but what the client wants to see or experience instead. So for example, if the client is suffering from depression, the conversation does not revolve around depression but on the client's goal, which may be "to be happy again", "to find enjoyment in life" or "to get the courage to start to meet people again". For every problem that a client may have, there always exists the opposite, a positive goal to achieve. SFT is not a method to help clients solve problems, but a method of helping clients achieve the opposite of the problem, that is positive goals. If the client is suffering from a fear, the therapeutic conversations would not focus on the fear but on the courage that the client wants to develop (in order to overcome his fear), and if the client has the bad habit of losing his temper, the therapy does not focus on the bad habit but on the better alternative habit, that the client needs to learn that will replace the bad habit.

The main technique used by therapist is useful questions. The therapists, for example, asks the client about their goals, what they have already done that has helped them move towards their goal, even just a little; what similar challenges they have solved previously in their lives; what personal resources they have that may help them achieve their goal; what resources they have in their family, or social network that may be useful to them, etc. A commonly applied solution-focused question is the "scaling question" where the therapist asks the client to assess where, on a scale from 1-10, they are in moving towards their goal when 1 is the situation at its worst and ten is goal achieved. Another well-known solution-focused question is the "future perfect" question where the therapist encourages the client to develop very concrete images and descriptions of how they would like their life to be in the future when there is no more need for therapy and they are satisfied with the result.

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SFT is an evidence-based therapy. It is a brief therapy but not a time-limited therapy. The number of sessions is not limited and can vary depending on the case. Usually the number of sessions is less than 10 but in some cases therapy lasts for much longer. SFT can be used in individual therapy as well as in family and group therapy.

SFT has been used successfully for treating all kinds of psychological and social problems. It is suitable for treating anxiety disorders, mood disorders, addiction problems, PTSD, childhood mental health issues, etc. Good results have been also achieve in suicide prevention, schizophrenia rehabilitation and child protection where a SF approach called Signs of Safety is becoming increasingly popular around the world. ■

# *How do I treat clients with psychological trauma and PTSD?*

Hans-Peter Söndergaard

**Hans Peter Söndergaard**
MD, Assistant Professor
Kris- och traumacentrum, Stockholm

**In psycho-traumatology,** real-life clients can be located on a trauma spectrum in which the most typical disorder is single-trauma PTSD, often found in a previously well-functioning subject with a secure attachment base. Many clients instead suffer from complex PTSD, a condition which can result from prolonged or recurring trauma during critical developmental phases, giving rise to difficulties with affect regulation and trust, negative self-concept, possibly self-destructive behaviour, and impaired ability to set limits or protect oneself. A third group might include subjects with prominent dissociative symptoms or even a dissociative disorder apart from PTSD.

Each of these victims of trauma might seek treatment after a recent traumatic experience with symptoms of PTSD. However, individuals in the third group also show a prominent attachment disorder. Such subjects might shift between different parts of the personality. While about one-third of chronic patients in general psychiatry meet criteria for a dissociative disorder, indications are that this has only rarely been recognised. Apart from knowing where the specific client might belong on the trauma spectrum, it is also important to assess commonly found co-morbidities, e.g. depression.

Comprehensive trauma assessment will deal with the patient's trauma history, PTSD symptoms, capacity for affect regulation, and possible dissociative symptoms. There are many different self-assessment tools with good psychometric properties. At present we use Life Event Checklist, PCL-5 for PTSD, HSCL-25 for anxiety and depression, assessment of dissociation using the DES Taxon, and the Somatoform Dissociation Questionnaire.

When reviewing self-report measures, it is crucial to confirm that the client has understood the questions, and if in doubt, one must rely on structured diagnostic interviews. In this regard it is recommended to acquaint oneself with CAPS for PTSD and SCID-D for dissociative disorders. These comprehensive tools while time-consuming provide a detailed assessment of symptoms. Although it might not be feasible to use clinician-administered structured assessment tools routinely, it is good to have them available.

With regard to pharmacology, it is important to note that there is presently no single drug or drug class specifically targeting PTSD, and for most drugs that are used, meta-studies indicate at best weak effects. It is important to avoid addictive substances such as benzodiazepines, which would always need to be tapered before it becomes possible to treat PTSD. SSRIs are the only drugs, which might be recommended routinely. While PTSD symptoms are sometimes misinterpreted as hallucinosis, neuroleptics turn out not to be effective. The alpha-1-adrenergic receptor antagonist prazosin can be extremely valuable for severe nightmares; unfortunately this is not a registered drug in Sweden, but is available on license from Sweden's MPA.

In single-trauma PTSD, any of the very efficient exposure-based methods can be readily used, as the research literature shows their effectiveness to be comparable. Many factors will influence the choice of method, including differences with regard to attrition from therapy, how soon a method can be expected to work, as well as therapist preference. Effective treatments include classical Prolonged Exposure therapy, Eye Movement Desensitisation and Reprocessing, and Narrative Exposure Therapy. All effective psychological treatments entail some form of exposure, i.e. confronting the traumatic experience.

In the case of complex PTSD, treatment proceeds in steps involving psycho-education, techniques for improving affect regulation such as mindfulness, breathing training or other techniques aimed at anxiety reduction, treatment of co-morbid conditions, and trauma-focused exposure. In the follow-up phase after successful treatment, patients often experience a period of extended mourning.

Psychotherapy is also appropriate for trauma-associated dissociative disorders. Treatment is generally lengthier, when compared to PTSD and even complex PTSD. Preparatory treatment phases for all three of these groups can successfully be implemented in a group format. In the future, it is entirely possible that multimodal stepwise therapy protocols will shorten treatment considerably.

*Important points:*

- Do not be afraid to ask about trauma: it is much worse to miss it entirely, or to not be aware that the client is having flashbacks. As strange as it might sound, the client can be completely unaware of the connection between disturbing symptoms and previous traumatic experiences.
- Avoid benzodiazepines, use SSRI as a first line treatment. Each encounter with a physician is a risk situation for another inefficient pharmacological intervention. In clinical practice, one meets patients with ineffective treatment with neuroleptics – that may have been prescribed due to hallucinatory re-experiencing during flashbacks or nightmares – yet who have never been offered trauma-focused psychotherapy, which is the first-line treatment for PTSD.
- Although patients with dissociative disorders should also be treated using psychological methods, exposure-based phases in therapy with this group will initially require treatment using other protocols. ■

**Quotes on humanistic psychotherapy**

"…the purpose of psychotherapy is to set people free "
***Rollo May***

"It is true that we can see the therapist as a technician only if we have first viewed the patient as some sort of machine "
***Viktor E. Frankl***

"A myth is a way of making sense in a senseless world. Myths are narrative patterns that give significance to our existence. Whether the meaning of existence is only what we put into life by our own individual fortitude, as Sartre would hold, or whether there is a meaning we need to discover, as Kierkegaard would state, the result is the same: myths are our way of finding this meaning and significance "
***Rollo May***

"Man is not what he believes himself to be in his conscious decisions "

***Paul Tillich***

"What is demanded of man is not, as some existential philosophers teach, to endure the meaninglessness of life, but rather to bear his incapacity to grasp its unconditional meaningfulness in rational terms. Logos is deeper than logic "
***Viktor E. Frankl***

# *"e-Mental Health: the future is now"*

Davor Mucic

e-mental health (eMH) is the use of telecommunication and information technologies to deliver mental health services at a distance. The oldest and most comprehensive form of eMH is telepsychiatry, i.e. videoconferencing in "real-time". Professionals at conferences in Denmark in the beginning of this century wondered: (1) "Is it suitable for in-person care?" and (2) "Is it just regular care by video or is it something different?" Others got confused more literally (e.g., "Is it something about telepathy?"). Today, others say, "It is just like Skype, isn't it?"

Within the last decade telepsychiatry has become slowly accepted. However, especially among senior colleagues a bit of skepticism remains. Narratives from daily clinical work may significantly increase the understanding and acceptance of eMH among professionals with no eMH related experience or professionals that are still in doubt.

So I share the following case with you:

*In 2002, NN was a 28-year-old female, refugee from Bosnia-Herzegovina. In Bosnia, during the war, NN was unfortunately raped several times while her husband was in the army. After immigrating to Denmark, NN was referred to a psychiatrist due to posttraumatic stress disorder. As her Danish language abilities were poor, the communication was provided via an interpreter. Consequently, she received psychiatric treatment with medication and psychotherapy via interpreter for around 3 years prior to our first telepsychiatry session. The video equipment was installed at the psychiatric department where NN used to come and speak with her psychiatrist in-person. I – speaking her mother tongue – was in Copenhagen while NN was located 245 km away in outskirts of Denmark. At the first consultation via telepsychiatry, the first question NN asked was, "Can all of Denmark see us now?"*

*When assured that no one follows our conversation and that the session will not be recorded, NN replied, "Then I have a secret I would like to disclose" and so she started her story about traumatic events, i.e., rape and torture in her home country. NN cried while speaking in a stream without a break except to wipe her tears and blow her nose. She said that it was not possible for her to speak about it with her past psychiatrist, as all communication runs via the interpreter. The presence of the interpreter for her changed the dynamic of the interview and more tangibly, it increased the risk that her husband would find out about the rape and consequently divorce her.*

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*While NN spoke about her painful experiences, the Internet suddenly disconnected. When that happens, the last frame remains on the screen as a frozen picture. So NN could see me as a still image and I could see her frozen in the middle of a movement and of course we could not hear each other. I panicked, thinking what she would say to this, fearing that she probably would never come again (i.e. use the video). My technician was in the office next door, so he restored the connection. The break lasted about 30 seconds, but it felt like much longer. To my surprise, when the connection was restored, I could see and hear NN who spoke in a stream and cried at the same time. She didn't even notice that I was gone for a while.*

Personally, it was an experience that shaped the next 15 years of my dedicated work on developing of the "cross-cultural telepsychiatry concept", whereby the treatment of ethnic minorities is possible without interpreters.

Within clinical practice, we have never been presented with the tool that requires so little investment while it in turn gives us so much, as is the case with eMH. When it becomes accepted as a supplemental tool able to enhance the quality of care and ease the daily clinical work, then we will probably see the use of technology in larger scale. ■

# *Why is CBT recommended?*

Signe Lykkegaard

The father of CBT is Aaron Beck. He developed this kind of therapy in the beginning of the 1960's. He featured a number of treatment elements, structure, goal setting, and short-term treatment. He asserts the importance of current maintaining factors rather than past assumed causes.

In CBT, the therapist is particularly interested in the patients' appraisals of their situation, which can be accessed through their thoughts, images and memories and may become the prime target for therapeutic changes. Within cognitive theory, cognition is held to exert its influence on emotion, behaviour and the physical reactions in at least two ways: first through the content of the cognition and second through the process of cognition. The content of cognition affects our emotions, behaviour and physiology. The process of the cognition influences our experience of the world, others and the self.

The treatment model is adjusted according to the psychiatric diagnosis, but common factors are negative automatic thinking and ensuing misinterpretations.

***Case:*** I had a young couple in therapy; they considered a divorce. They had very few good times together and were always quarreling. They have had many challenges: she was depressive, and her condition got worse as a result of their crises. And they had a child with many challenges. The goal of the therapy was not that they had to be together, but they had to work together around the child until he was grown up and could manage by himself.

We worked with their expectations of each other, those which were not verbalized, and their misinterpretations and thoughts about the others intensions. As homework, they were to nurture each other, get a child nurse a couple of days every week and do something together and alone. They acknowledged a great devotion for each other and ended up wishing to be together, and their relationship got beautiful and strong. The therapy amounted to 16 hours with a follow-up twice a year by mail. *The couple has consented in being part of this article.*

**How to become a cognitive therapist I Denmark**

To become a cognitive therapist in DK, for doctors, you have to have encountered a lot of patients with psychiatric problems and finished your basic training in

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therapy – in psychodynamic, group therapy, and cognitive therapy. Then it is possible to start training in CBT. The training comprises as per 2015 160 hours of theory, increasing in 2019 to 200 hours. One must carry out 130 hours of therapy, increasing to 160 in 2019. Supervision must be received in groups for 120 hours and individual 80 hours, increased to 130 to 200 hours' supervision. Personal development comprises 40 hours with video to monitor personal style.

The psychologists have different rules because their education/training is different, but very often medical doctors and psychologists attend the same course. Medical doctors are required to write a paper, and when that is accepted they have completed their education. ■

**Literature**

*Oxford Guide to Behavioural Experiments in Cognitive therapy* Edited by James Bennett Levy, Gillian Butler, Melanie Fennel, Ann Hackmann, Martina Muellre and David Westbrook. Oxford University Press 2006

*Kognitiv terapi. Nyeste udvikling. Mikkel Arendt og Nicole K. Rosenberg* Hans Reitzels Forlag 2012

Kognitiv Adfærdsterapi Grundlag og perspektiver Judith S. Beck 2. udg. Akademisk Forlag 2011 in English Cognitive Behavior Therapy – basic and beyond).


NORDIC PSYCHIATRIC ASSOCIATIONS

# Highlights from the Nordic Journal of Psychiatry

Martin Balslev Jørgensen

**Mental health of military veterans after deployment in Afghanistan**

Deployment of soldiers is associated with mental disorders after redeployment. This study aimed through a retrospective questionnaire to identity prevalence of probable mental disorders and associated factors among male Norwegian soldiers at a mean of 4 years following deployment to Afghanistan in 2001–2011. The prevalence of subjects with mental health problems was 5.1%. It was concluded that among male Norwegian veterans from Afghanistan, the prevalence of mental health problems was low, and mainly associated with post-deployment factors. Veterans complaining of mental symptoms should be diagnosed, treated, and examined for other problems of life.

**Hougsnæs S, Bøe HJ, Dahl AA, Reichelt J.G** Norwegian male military veterans show low levels of mental health problems four years after deployment in Afghanistan. *Nordic J Psychiatry* 2017; 71: 26-32.

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**Are eating disorders increasing in prevalence?**

There is an ongoing debate whether eating disorders are increasing in prevalence. By means of a classroom survey, Adolescent Mental Health Cohort study was carried out among the 9th graders in comprehensive schools in Tampere, Finland, during academic year 2002–2003, and replicated 2012–2013. No changes were observed in the prevalence of anorexia and bulimia. Eating disorders, treatment contacts due to eating disorders, and eating disorder symptoms were not systematically associated with either low or high parental socio-economic status. It is concluded that adolescent eating disorders are not associated with socio-economic status of their family.

**Litmanen J, Fröjd S, Marttunen M, Isomaa R, Kaltiala-Heino R.** Are eating disorders and their symptoms increasing in prevalence among adolescent population? *Nordic J Psychiatry* 2017; 71: 61-66.

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**Outcome of first-episode acute and transient psychotic disorder in Hong Kong Chinese: a 20-year retrospective follow-up study**

Acute and transient psychotic disorder (ATPD) remains relatively under-researched, despite controversies over its nosological status. This retrospective longitudinal study based on review of medical records assessed the changes in diagnosis over time and aimed to identify factors predicting changes in diagnosis, and compare the long-term outcomes of various patterns of diagnostic shift. Of the 87 subjects initially diagnosed as ATPD, 64.4% had their diagnoses revised over an average of 20 years, mostly to bipolar disorder and schizophrenia. Among those with diagnosis of ATPD unchanged, 54.8% had one single episode, while the remaining 45.2% had recurrence. Subjects with diagnostic shift had significantly younger age of onset, more first-degree relatives with a history of mental illness, and more subsequent psychiatric admissions. It is concluded that ATPD is likely a composite category consisting of clinically distinct outcome groups.

**Poon JYK, Leung CM.** Outcome of first-episode acute and transient psychotic disorder in Hong Kong Chinese: a 20-year retrospective follow-up study. *Nordic J Psychiatry* 2017; 71: 139-144.

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

### Self-referral to inpatient treatment vs treatment as usual in patients with severe mental disorders

There has been a call for increased patient autonomy and participation in psychiatry. Some Health Centres (CMHC) have implemented services called 'self-referral to inpatient treatment' (SRIT) for patients with severe mental disorders. This randomized controlled trial aimed to investigate whether SRIT could yield better outcomes for people with severe mental disorders than Treatment As Usual (TAU). Twenty out of 26 participants (77%) in the SRIT group used the SRIT for a median of 1.5 admissions and 5 inpatient days. With the exception of a somewhat larger number of admissions in the SRIT group, no significant differences were found between the two groups in days as inpatients, admissions, outpatient contacts or coercion. Both groups reduced their inpatients days by 40%. Giving patients with severe mental disorders the possibility to self-refer did not change the use of services. And it concluded that self-referral to inpatient treatment for patients with severe mental disorders might increase patient autonomy, but does not seem to save use of inpatient services.

**Sigrunarson V, Moljord IEO, Steinsbekk A, Eriksen L, Morken G** A randomized controlled trial comparing self-referral to inpatient treatment and treatment as usual in patients with severe mental disorders. *Nordic J Psychiatry* 2017; 71: 120-125. ■