



Young
Psychiatrists
Network



International conference

4th Young Psychiatrists' Network Meeting

*“A coin with many sides:
different perspectives on mental illness”*

April 03-05, 2014



Programme and abstract booklet

Wroclaw Medical University



Young
Psychiatrists
Network



International conference

4th Young Psychiatrists' Network Meeting

*“A coin with many sides:
different perspectives on mental illness”*

April 03-05, 2014

Programme and abstract booklet



Scientific edition

4th Young Psychiatrists' Network Meeting “A coin with many sides: different perspectives on mental illness”, April 3-5 2014, Wroclaw, Poland. International conference: Programme and abstract booklet. – Wroclaw: Wroclaw Medical University, 2014. - 66 p.

ISBN 978-83-7055--582-5

Editorial Board:

D. Krupchanka, MD, PhD student, Department of Service Management in Psychiatry, “Minsk Regional Clinical Center of Psychiatry and Narcology”, Minsk, Belarus;

N. Kruk, MD, assistant of department of medical psychology and psychotherapy, Grodno State Medical University, Grodno, Belarus;

L. Bukelskis, MD, Vilnius University Faculty of Medicine Clinic of Psychiatry, Vilnius, Lithuania;

D. Frydecka, MD, PhD, MSc Eng, Wroclaw Medical University, Wroclaw, Poland;

J. Hanson, MD, PhD, Assoc. Prof., Sweden;

G. Lydall, MBBCh, MRCPsych, Castel Hospital, Guernsey, Channel Islands, Great Britain;

T. Gondek, Department of Psychiatry, Wroclaw Medical University, Wroclaw, Poland

“United we stay, divided we fall”

Patrick Henry

*We are from **different worlds**,
With **different stories** behind
and **plenty of ways** in front of us*

*But TOGETHER we could overcome a lot of challenges
to understand that we need each other
to feel that we are strong when we are together
to open a new page of our story*

The story of Young Psychiatrists' Network Meetings.

Dmitry Krupchanka

CONTENT

PROGRAMME OF THE MEETING	7
LIST OF SPEAKERS	10
GOALS AND VISIONS OF YOUNG PSYCHIATRISTS NETWORK.....	13
Historic background.....	13
Our mission, vision and values	14
DESCRIPTION OF ACTIVITIES.....	14
Networking.....	14
Annual network meetings	14
Why are the activities of this network unique?.....	15
Past annual network meetings.....	16
Publications and presentations about network activities:	19
ABSTRACTS OF LECTURES AND WORKSHOPS.....	21
Abstracts of lectures.....	22
Davidson M. ECNP supported talk: ‘Randomness and causality in psychiatric clinical practice and research’	22
Gaebel W. Excellence in psychiatric service: a program for the future.....	23
Höschl C., Španiel C. Art and neuroscience	24
Landin-Romero R. From eye movements to mood stabilization: the role of trauma in bipolar disorder	25
Pagani M. Functional neuroimaging and eeg monitoring in emdr treatment	25
Paravaya O. Special session: associations of young psychiatrists	26
Roth J., Serranová T. Functional movement disorders	27
Sartorius N. Research and mental health care: issues, challenges and benefits.....	28
Saunders J. Family experience of mental ill health.....	28
Thornicroft G. Global Mental Health	29
Abstracts of workshops.....	30
Workshop session: “My psychiatry” (J.Hanson, W.Rutz, W.Gaebel, N.Sartorius)	30
Hanson J. My psychiatry	31
Rutz W. This is my psychiatry.....	32
Gaebel W. My psychiatry	33
Sartorius N. My psychiatry.....	34
Workshop session: The project to face stigma of mental disorders «konstigma» (M.Bendix, D.Krupchanka)	35
Workshop session: Psychoanalytic perspective of splits in consciousness and perception of loss of control creating ‘false’ anxiety (S.Kocak).....	35
Workshop session: Open dialogue (M.Klapcinsky)	36
Workshop session: Gender dysphoria in sweden - the role of the evaluating team (K.Kosidou)	37
Workshop session: Antipsychiatry (D.Krupchanka).....	37

Workshop session: Trauma and dissociation workshop (identification and treatment of dissociative disorders in lithuania(J. Mikaliūnas).....	38
Workshop session: Psychosocial rehabilitation importance and development in the treatment of mental disorders (E. Mikaliūnas).....	39
Abstracts of participants.....	41
Belugina O.S. et al. Psychological features of social position of patients with psoriasis	42
Bendix M. et al. Mental illness in sweden: a coin with many sides	43
Dąbkowska A. Neuroanatomy and neurophysiology of anxiety disorders in developmental age	44
Drapala J., Frydecka D. On the use of summary statistics and computational models for behavioural data analysis	45
Gołaska P. Autism spectrum disorders as a post-traumatic developmental disorder	46
Gondek T.M. et al. Mortality in schizophrenia: review of european literature from recent years	46
Herbinger G. et al. Two faces of polyunsaturated fatty acids in dementia.....	47
Kłapciński M. Open dialogue approach, about the phenomenon of finnish psychiatry.....	49
Kłosińska E. Psychological treatment in schizophrenia - needs and challenges	50
Korzyńska W. A patient with paranoid schizophrenia and recurrent noncardiogenic pulmonary edema – a case report.	51
Kreff M. Genetic awareness in psychiatric practise	52
Kreff M. When to suspect prader-willi syndrome in psychiatric patients	53
Moustafa A. Reward and punishment learning in schizophrenia and bipolar disorder: experimental and computational data	53
Polyakovskaya T. Minor psychiatric illness of climacterium: involitional hysteria (conceptions, typology and psychosomatic relations)	54
Reutfors J. Mood-stabilizing medication after hospitalization for bipolar disorder in sweden.....	55
Biliūtė-Rodinienė E.B. et al. Diagnosis and management of catatonia	56
Skowron B. Topology of the person	56
Śliwińska Z. What are the consequences of using neuropsychological methods by psychiatrist?	57
Sokoła K. Creativity and psychopathology	58
Szaulińska K. Tattoos on psychiatrists and psychotherapists.....	60
Szaulińska K. Throwing a dice: different perspectives on mental illness	61
Zarzycki R. Hyperreality - a remedy or a poison?.....	62
Zawadzka A. Sadder but smarter	62
ORGANISING COMMITTEE	64

PROGRAMME OF THE MEETING

1st Day (3rd April)		
Venue: Department of Psychiatry, Medical University of Wrocław (Wybrzeże L. Pasteura Street, 10)		
8:00-9:00	REGISTRATION	
9:00 –9:30	OPENING (Chairpersons: Jerker Hanson, Dorota Frydecka)	
	Organising committee address	Organizing committee
	Complimentary speech from the Head of the Department of Psychiatry Med. University of Wrocław	Andrzej Kiejna
	Complimentary speech from the Chairman of the Polish Psychiatric Association	Jan A. Beszlej
	LECTURES (Chairpersons: Dmitry Krupchanka, Nina Kruk)	
9:30-10.30	Research on mental health care: issues, challenges and benefits	Norman Sartorius
10:30 - 11:30	Global Mental Health	Graham Thornicroft
11:30-12:00	<i>Coffee break</i>	
12:00 - 13:00	Excellence in Psychiatric Service: A Program for the Future	Wolfgang Gaebel
13:00 - 14:00	<i>Lunch</i>	
14:00 - 16:00	WORKSHOPS	
	1	“My psychiatry” Wolfgang Rutz, Jerker Hanson, Wolfgang Gaebel, Norman Sartorius, Dmitry Krupchanka
	2	Open Dialogue Werner Schuetze, Michał Klapcinski
16:00 - 16:30	POSTER SESSION (Chairpersons: Jerker Hanson, Jonas Mikaliūnas)	
18:00 – 22.00	<i>presentations & welcome cocktail party</i>	

2nd Day (4th April)		
Venue: Department of Psychiatry, Medical University of Wrocław (Wybrzeże L. Pasteura Street, 10)		
9:00 - 9:15	Opening / Introduction to the 2nd day	
	LECTURES (Chairpersons: Nina Kruk, Laurynas Bukelskis)	
9:15 - 10:15	Functional movement disorders: the neurologist's perspective	Jan Roth, Tereza Serranova
10:15 - 11:15	EU mental health politics review and what was achieved during Lithuanian presidency of the Council of the EU	Arūnas Germanavičius
11:15 - 12:15	ECNP supported talk: 'Randomness and causality in psychiatric clinical practice and research'	Michael Davidson
12:30 - 13:30	<i>Lunch brake</i>	
13.30 - 15.00	Psychiatry from perspectives of different professions	Academy of Young Scholars and Artists from Wrocław (Chairpersons: Dorota Frydecka, Roland Zarzycki)
15:00 - 17:00	WORKSHOPS	
	1	"Psychosocial rehabilitation importance and development in the treatment of mental disorders"
	2	Gender dysphoria in Sweden- the role of investigating team
	3	The project to face stigma of mental disorders «KonStigma»
17:00 - 17:10	<i>Coffee break</i>	
17:10 - 18:10	BARCAMP (Chairpersons: Olga Paravaya, Michał Kląpinski,) Young Psychiatrists presentations	
18:30 - 20:30	SIGHTSEEING WROCLAW	

3rd Day (5th April)		
Venue: Department of Psychiatry, Medical University of Wrocław (Wybrzeże L. Pasteura Street, 10)		
8:45 - 9:00	Opening / Introduction to the 3rd day	
	LECTURES (Chairpersons: Jonas Mikaliūnas, Marzena Olędzka)	
9:00 - 10:00	Functional neuroimaging and EEG monitoring in EMDR treatment	Marco Pagani
10:00 - 11:00	From eye movements to mood stabilization: the role of trauma in bipolar disorder	Ramon Landin-Romero
11:00 – 11:30	<i>Coffee break</i>	
	LECTURES (Chairpersons: Dmitry Krupchanka, Dorota Frydecka)	
11:30 - 12:45	Service users families perspective toward mental health	John Saunders (EUFAMI)
12:45 - 13:30	Art and neuroscience	Cyril Höschl
13:30 - 14:30	<i>Lunch brake</i>	
14:30-15:30	Symposium of Young Psychiatrists Associations (Chairperson: Olga Paravaya) EFPT (Athanasios Kanellopoulos, Mariana Pinto da Costa) ECPC (Alexander Nawka) ECNP J-mind (Olga Paravaya) WPA (Marie Bendix)	
15:30- 17:00	WORKSHOPS	
	1	Antipsychiatry
	2	Psychoanalytic perspective of splits in consciousness and perception of loss of control creating ('false') anxiety
	3	Trauma and dissociation workshop
17:00-18:00	SUMMARIES (Organising committee)	
20:00 - ...	<i>International party</i>	

LIST OF SPEAKERS

- Alexander Nawka MD, member of the Early Career Psychiatrists Committee of the European Psychiatric Association, Past-President of European Federation of Psychiatric Trainees (EFPT), Prague, Czech Republic
- Arūnas Germanavičius MD, PhD, Assoc.Prof. in Psychiatry, Clinic of Psychiatry, Faculty of Medicine, Vilnius University, Vilnius/Lithuania
- Athanasios Kanellopoulos Child and Adolescent Psychiatrist, EFPT CAP Secretary, Association for the Psychosocial Health of Children & Adolescents, Scientific Associate Evgenidion Therapeftirion, National & Kapodistrian University of Athens, Greece
- Marie Bendix WPA Early Career Council, f. President Swedish Psychiatric Trainee Association, psychiatrist, Karolinska University Hospital Huddinge, Stockholm/Sweden
- Cyril Höschl Professor of psychiatry and chairman, Psychiatric Department, 3rd Faculty of Medicine, Charles University in Prague, Director, Prague Psychiatric Center/NIMH, Czech Republic. In 2007-8 President of EPA (European Psychiatric Association), 2008-9 President of FEAM (Federation of European Academies of Medicine). Board member, European Brain Council. Areas of expertise include Psychoneuroendocrinology, Psychopharmacology and Biological Psychiatry.
- Dmitry Krupchanka MD, PhD student, Department of Service Management in Psychiatry, “Minsk Regional Clinical Center of Psychiatry and Narcology”, Minsk, Belarus;
- Dorota Frydecka, MD PhD in Psychiatry, M.Sc. Eng. in Computer Science and M.A. in Psychology, Department of Psychiatry, Wroclaw Medical University, member of Young Academy of Scholars and artists, member of Task Force on Research or Publications of EPA Early Career Psychiatrists Committee (ECPC), Poland
- Eugenijus Mikaliūnas Director of Psychiatric Clinic of Republican Siauliai Hospital, Siauliai/ Lithuania
- Graham Thornicroft Professor of Community Psychiatry works at the Health Service and Population Research Department at the Institute of Psychiatry, King’s College London, Consultant Psychiatrist working in a community mental health team in South London. His areas of expertise include: mental health needs assessment, the development of new outcome scales, cost-effectiveness evaluations of mental health treatments, stigma and discrimination, and global mental health. He Co-Chaired the WHO MHGap Guideline Development Group.

Jan Roth	Professor, MD, PhD. The Head of Movement Disorders Center Department of Neurology and Center of Clinical Neuroscience Charles University in Prague
Jerker Hanson	Psychiatrist, MD, PhD, Ass.prof., Stockholm, Sweden
John Saunders	Treasurer and Board member of EUFAMI (European Federation of Associations of Families of People with mental illness), Director of SHINE (Supporting People Affected by Mental Ill Health)
Jonas Mikaliūnas	Psychiatrist, Vilnius/Lithuania
Kyriaki Kosidou	MD, PhD, psychiatrist at Stockholm County Council, Stockholm, Sweden
Marco Pagani	Senior Researcher (Primo Ricercatore) at the Institute of Cognitive Science and Technology of the Italian National Research Council (ISTC-CNR) and Chair of the European Neuroimaging Committee of EANM
Mariana Pinto da Costa	President Elect of the European Federation of Psychiatry Trainees (EFPT) Psychiatry Trainee at Hospital Magalhães Lemos, University of Porto, Portugal
Marie Bendix	WPA Early Career Council, f. President Swedish Psychiatric Trainee Association, psychiatrist, Karolinska University Hospital Huddinge, Stockholm, Sweden
Michael Davidson	MD, Professor and Chairman, Department of Psychiatry, Tel Aviv University, Chief Editor European Neuropsychopharmacology, invited speaker on behalf of ECNP
Michał Kłapciński	PhD student, Department of Psychiatry, Division of Consultation Psychiatry and Neuroscience
Norman Sartorius	Professor, President, Association for the Improvement of Mental Health Programmes (AMH), Geneva, Switzerland
Olga Paravaya	MD, PhD student, Belarussian Medical Academy of Postgraduate Education, Belarus, Minsk,
Ramon Landin-Romero	Junior Researcher, FIDMAG Research Foundation, Barcelona, Spain
Salise Kocak	Senior Lecturer in Psychology Department of the American University of Cyprus.
Teresa Serranova	MD, PhD, Department of Neurology, First Faculty of Medicine, Charles University in Prague and General University Hospital in Prague
Werner Schuetze	Psychiatrist, Psychotherapist, Childrens- and Youth Psychiatrist, Familytherapist, Head of a Psychiatric department til 2013 where the Open Dialogue treatment approach was implemented, since then promoter, lecturer and trainer in Open Dialogue

- Wolfgang Gaebel MD, PhD, Professor, Director of the Department of Psychiatry and Psychotherapy, Heinrich-Heine-University; President Elect of the European Psychiatric Association (EPA); Acting President of the European Scientific Association of Schizophrenia and other Psychoses (ESAS); Chair of the Section on Schizophrenia of the World Psychiatric Association (WPA), Co-Chair of the Section on Quality Assurance; Chair of the Taskforce on Nosology and Psychopathology of the World Federation of Societies of Biological Psychiatry (WFSBP); Co-Chair of the EPA Section on Schizophrenia; Speaker of the German Competence Network on Schizophrenia (CNS), Dusseldorf, Germany
- Wolfgang Rutz Professor, MD, PhD, Regional Advisor Mental Health, WHO Europe (retired), Past President of Swedish Society for Biological Psychiatry, Past Vice President of Swedish Psychiatric Association, Senior Consultant of University for Applied Sciences in Coburg/Germany, Stockholm, Sweden

Speakers On Behalf Of

ACADEMY OF YOUNG SCHOLARS AND ARTISTS FROM WROCLAW

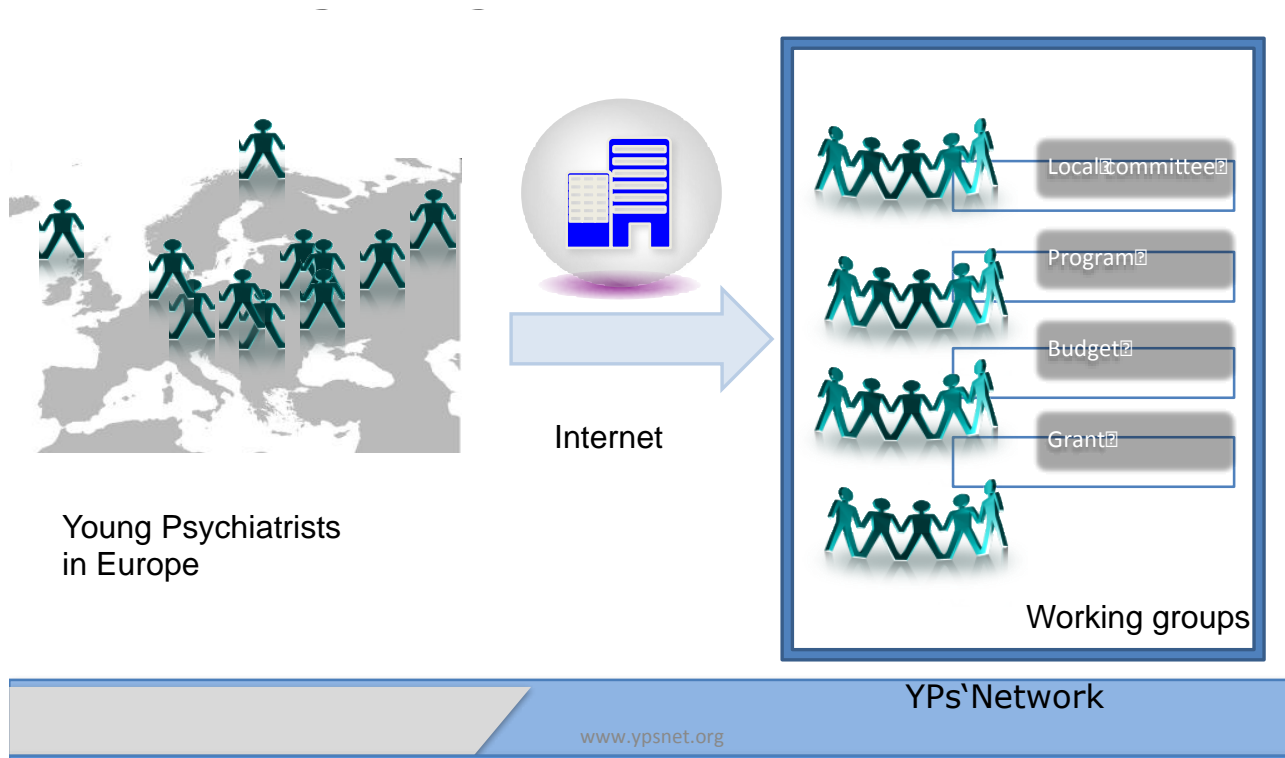
- Ahmed Moustafa Lecturer in Cognitive and Behavioural Neuroscience at the Marcs Institute for Brain and Behaviour & School of Social Sciences and Psychology, University of Western Sydney
- Bartłomiej Skowron PhD in Philosophy, BA in Mathematics, University of Wrocław, fellow of the Academy of Young Scholars and Artists
- Jarosław Drapała PhD from the Wrocław University of Technology, Faculty of Computer Science and Management. In 2004 he started working at the Institute of Informatics. Participant of „Future Internet” project, with special focus on biomedical signal processing and complex systems modelling. His main interests include identification of complex systems, numerical methods, neural networks, pattern recognition, statistical analysis and machine learning.
- Roland Zarzycki PhD in mathematics, PhD student at the Social Sciences Faculty, academic teacher, researcher and coordinator of scientific research projects. Co-author of the Wrocław application for the European Capital of Culture title, currently working on the project. Involved in various social initiatives, activist, publicist and vegetarian

GOALS AND VISIONS OF YOUNG PSYCHIATRISTS NETWORK

Historic background

The Young Psychiatrists¹ Network was born in 2009 as "Young Psychiatrists Eastern Europe" due to an initiative from the – no longer active - Swedish Eastern Europe Committee (SEEC/ÖEK) and facilitated by a grant from the Swedish International Development Agency (SIDA). SEEC had, during its last years, made a special effort to address needs and concerns of young psychiatrists (YP) in the Baltic Sea Region and Belarus.

After initial discussions of common goals and possibilities to promote networking between YPs from Lithuania, Russia and Sweden in Kaliningrad in 2009, the first step was to create a web-based platform. (<http://groups.google.com/group/young-psychiatrists-eastern-europe>). By the means of Internet-facilitated interactions (Skype) between YPs from Latvia, Lithuania, Belarus, the UK and Sweden, the first international meeting was organised. It took place in Vilnius in 2010.



¹ Young psychiatrists are psychiatrist or trainees under the age of 40 or within 5 years of completion of the training

Our mission, vision and values

VISION

Our vision is global development of psychiatry through close co-operation of YPs worldwide, expanding knowledge and sharing experiences, giving the means to influence psychiatric care at local and international level.

MISSION

Facilitating the evolution of YPs from different parts of the world, and improvement of their knowledge, skills and abilities by close interactions, utilising modern technological communication as well as meeting in person.

VALUES

Striving to identify and communicate the highest level of clinical care, respecting patients' rights, national diversity, cultural tradition, and working towards destigmatising psychiatric illness in society. The interaction between members of the YP network is grounded in mutual respect, openness, friendship and lack of a hierarchy- encouraging an open dialogue and friendly atmosphere.

DESCRIPTION OF ACTIVITIES

Networking

Organizing group activities, including meetings, and increase the visibility of Young Psychiatrist (YP) in international meetings and through publications, concentrating on YP educational needs.

- Networking with national and other international organizations (World Psychiatric Association, European Psychiatric Association, European Federation of Psychiatric Trainees, Asian Association of Young Psychiatrists) where many network members have official positions;
- Continuous Internet communication through Skype, Google groups, Facebook, LinkedIn and our homepage ensure easier contact between interested YPs;
- Facilitating processes of establishment of national YP associations by sharing experiences from international YP colleagues;
- Facilitate personal contact between YPs, resulting in visits between countries and research collaborations.

Annual network meetings

– The annual network meetings are open to all interested YPs and not restricted to members of the boards of different psychiatric associations and organisations. The focus of the meetings is to share educational experiences between eastern and western countries, and foster discussion about providing quality psychiatric care. Meetings are characterized by a learning environment where it is

possible to learn, and practically implement leadership and presentation skills (workshop presentations, research presentation). An important part of the meetings is visits to local psychiatric hospitals, aiming to provide direct insight into local psychiatric care. The quality and content of the meetings are evaluated, and results provide the basis for program development;

- Our meetings are organized by an organizing committee of dedicated volunteers among YPs - “by Young Psychiatrists for Young Psychiatrists”. Membership is possible for any interested YP regardless of their status in their national association. In this way we are offering equal possibilities for all interested YPs in the work of the organizing committee. This function is through working groups, which facilitate open and democratic discussion. The budget for our annual meetings is planned carefully, aiming to accommodate participants from low-income countries and at the same time allowing international experts to participate without any economic reimbursement;

- Funding of our meetings in the past was provided 2009 by the Swedish Eastern European Committee (SEEC), 2010 and 2011 the Swedish International Development Cooperation Agency (SIDA) and in 2011 the World Psychiatric Association (WPA);

- Our experience has shown that these annual meetings are a crucial part of the network in general, as they give YPs the possibility to interact face-to-face and not only indirectly through the Internet.

Why are the activities of this network unique?

- Open to all interested YPs - not only active members in national and international organizations;
- Not just another conference. Focus on exchange of knowledge, experience, interaction, collaboration and skills training;
- Not just another international organisation – network to bridge between individuals and organisations for all YP;
- Including trainees and young specialists (until age 40 or maximum 5 years from specialist degree) adapting to vast differences in international training;
- Interaction with other related professions than psychiatrists to reflect international differences in professions in psychiatry (psychologists, psychotherapists, public mental health professionals);
- Independent partnership with national and international professional organizations.

Past annual network meetings

1st YPN Meeting: Vilnius 2010



The 1st YPN Meeting happened in Vilnius, Lithuania in 2010, and was attended by 50 YPs from 10 European countries. The evaluation and consecutive discussions by those who had attended the meeting in Vilnius suggested that the idea of a network – outside of common established organisations and created only by YPs for YPs – was something new and useful. Interest in participation in arranging a follow up conference was high and also YPs from Poland, Russia and Estonia joined the organising committee.

2nd YPN Meeting: Riga 2011



The 2nd YPN Meeting was held in Riga in April 2011 and was partially sponsored by the WPA (World Psychiatric Association), which allowed the organizers to invite 90 participants from 18 countries. Participants answered questions about the current meeting and interest in further development of the network (response rate 74%). Results of the survey showed that overall interest in further similar meetings were high. But 2/3 of participants from mainly eastern European countries stated that they could not have attended the meeting without economic support. On the other hand 1/3 of participants stated that they would return even without economic support. As the annual meetings are to be considered only a part of network activities we also included questions to those participants who had also attended the meeting in Vilnius the year before (12 participants). They stated that the meeting only partly had resulted in changes in their behaviour regarding diagnostics and treatment (average 3,5 on 5-grade Likert scale 1 = not at all to 5 = very much) despite that the academic part of the program in Vilnius focused on diagnostics. On the other hand network effect results were striking: All returning participants stated that they had had indirect contact with international colleagues during the year following the meeting (e g via internet) and 60% had had personal contacts (e g through individually arranged study visits or meetings at other conferences). There were also effects on local and international level concerning engagement in YP related activities: 83% were after the meeting in Vilnius involved in national trainee or YP associations and 67% in international organisations outside the network. Concerning promotion of international research activities, 17% stated that they had established international research contacts. The organisers' conclusion of the evaluation was that these meetings seem to reach the goal to build bridges between eastern and western European YPs and also promote engagement in other associations both nationally and internationally. These meetings are not only seen as another international conference but are regarded by participants as a meeting place resulting in continuous personal interaction, organisational and research activities. Since the meeting in Riga 2011 an intensive contact has taken place between a growing organisation committee for the planning of a meeting in Minsk in September 2012, where YPs from Germany, Croatia and Greece joined the prior group. But also contacts with other international YP organisations (including World Psychiatric Association, European Psychiatric Association, European Federation of Psychiatric Trainees, Asian Association of Young Psychiatrists) have been established and were strengthened. The network became an official working group of the European Federation of Psychiatric Trainees. Publications and presentations (see list below) in international settings were produced by network members. Further Internet collaboration between members now also takes place through Facebook and LinkedIn. The network also developed its own homepage: www.ypsnet.org

3rd YPN Meeting: Minsk, 2012



The 3rd YPN Meeting took place 27-29th September 2012 in Minsk, Belarus. The meeting was titled "*Stigma from the YPs' perspective: Hopes and Challenges*". After inspiring lectures participants had several opportunities to share their views on the issue of stigma during workshops and poster sessions with experienced professionals: Wolfgang Rutz, Levent Kuey, Aleksandar Janca, Wolfgang Gaebel, Henrik Wahlberg, Afzal Javed, E. Mohandas, Roman Evsegneev, Oleg Skugarevsky and Jerker Hanson.

The emphasis of the meeting was to involve young colleagues as much as possible. The conference booklet with participants' abstracts was also published. Psychiatric service users made a contribution to the conference by exhibiting their paintings, the best painting being awarded by a prize. The importance of the meeting was emphasized by the fact that it was the first international psychiatric conference to be held in Belarus. It was attended by 74 participants from 21 countries (Armenia, Australia, Belarus, Czech Republic, Denmark, Estonia, Finland, Germany, Greece, India, Latvia, Lithuania, Norway, Poland, Portugal, Russia, Serbia, Sweden, Switzerland, Turkey, UK), and supported by the European Federation of Psychiatric Trainees (EFPT), Ministry of Health of the Republic of Belarus, Belarusian Medical Academy of Postgraduate Education (BelMAPGE), Belarusian Psychiatric Association (BPA) and Rotary Club "Minsk".

At the end of the conference participants filled in an anonymous evaluation form. 52 participants (70%) from 14 countries returned the survey. It was the first YPN meeting for 60% of them. The meeting was evaluated positively by all participants, and 44% expressed a wish to actively organize a consecutive meeting. According to the evaluation most of the participants especially appreciated the warm and friendly atmosphere in which everyone could share their ideas and freely address questions to outstanding professionals in the field. The majority of participants thought that the meeting would have positive effect on their professional career (81%) and personal development (88%). Some questions addressed the 21 participants (40%) who already had attended

the previous meeting (2nd YPN meeting in Riga, 2011) in order to measure effects on YPs' activities in the past year. 30% of participants of the Riga meeting stated that the meeting changed their clinical practice, 90% reported indirect and 86% direct personal contact with international colleagues after the meeting. As the result of previous meeting 81% of them became involved in national and 62% in international trainee/YPs organizations. 52% established international research contacts. Participants from Poland, Russia and Portugal considered hosting the next meeting. Wroclaw received the most votes, closely followed by Moscow. A new organizing committee team for the 4th YPNM was created.

4th YPN Meeting: WROCLAW, POLAND

– a city hosting current 4th Young Psychiatrists' Network Meeting

Located at the Odra River, at the crossroads of Europe, neighbouring Vienna, Prague, Kraków, Berlin and Warsaw Wrocław melts with equal parts Austrian Hapsburg charm, Prussian pride, Polish playfulness and Bohemian rhapsody. There is plenty reasons why you may wish to visit the capital of Lower Silesia. Within the city boundaries tributary of 5 rivers extorted erection of numerous bridges. Their considerable amount, together with the association with romantic Venetian atmosphere lead to entitle Wrocław "Venice of the North". Approaching the city center emerges awe - inspiring Market Place meticulously restored in year 2000 for its millennial anniversary. In terms of size in Poland it is second only to Kraków's. Significant metamorphosis which Wrocław underwent in recent years added a touch of glamour also to resplendent Cathedral Island – the historical heart of the city, made of botanical garden, Odra river banks, paved paths, late gothic churches all illuminated by warm, XIX century, gas-lantern light. Not to mention absolutely must-see siege of a one-of-a-kind UNESCO rewarded architectonic gem - the Centenary Hall. Beyond everything Wrocław offer very friendly and festive atmosphere where more than 120,000 university students push local nightlife to unhinged heights. Culturally rich, Wrocław successfully celebrated the Euro 2012 football championships, hosting the Polish National Football Team. Awarded the title of "European Capital of Culture 2016", the city heads towards organizing another distinctive event. Wrocław – the Meeting Place, is one of the most exciting destinations in Poland.

Publications and presentations about network activities:

1. Publications:

- Bendix M, Olofsson M, Hanson J: Young Psychiatrists Meetings. Tidskriften för Svensk Psykiatri #3, Sept 2010, 80-81;
- Bendix M, Jauhar S, Smirnova D, Bezborodov N, Baessler F, Hanson J, Rusaka M: Svensk psykiatrisk förening i europeiskt samarbete moving together towards new horizons – 2nd Young Psychiatrists' Network Meeting, Riga 2011. Swed. Med. Assoc. Actualities, 2011:3:35;
- Bendix M, Jauhar S, Smirnova D, Bezborodov N, Baessler F, Hanson J, Rusaka M. moving together towards new horizons – 2nd Young Psychiatrists' Network Meeting, Riga 2011 http://www.wpanet.org/detail.php?section_id=22&content_id=1046

- Bendix M, Paravaya O, Kochetkov Y, Jauhar S: Young psychiatrists' meetings in Eastern Europe - Networking for the development of psychiatric training, education and service. *World Psychiatry* 2011 Oct; 10(3): 239.
- Отчет о 2-ой международной конференции молодых психиатров (Рига, Латвия) Бомов П., Шмунк Е., Кочетков Я. (Report of the second international conference of young psychiatrists (Riga, Latvia) Bomov, P., E. Shmunk, Kochetkov, J. To be published in *Social and Clinical Psychiatry*);
- Paravaya O, Krupchanka D: Report about 2nd YPs Network Meeting in Belarusian journal "Psychiatry, Psychotherapy and Clinical Psychology". 2(04), 2011. – P. 148;
- Rautanen M: Nuoret psykiatrit verkostoituivat Itämeren ympärillä (Young psychiatrists networking around the Baltic Sea). *Journal of Junior Doctors' Association in Finland*, 2011: 3: 32;
- Reutfors J, Bendix M, Hanson J, Kosidou K, Olofsson M: Framgångsrikt kunskapsutbyte mellan psykiatrer från öst och väst. *Tidskriften för Svensk Psykiatri* #2, Juni 2011, 38-39;
- "2-я конференция молодых психиатров в Риге'2011: вместе к новым горизонтам Смирнова Д.А. (СамГМУ, г. Самара), Кочетков Я.А., Семиглазова М.В. (МНИИП, г. Москва)". To be published in *Psychiatry and Psychopharmacotherapy*;
- Smirnova D., Krupchanka D. Third young psychiatrists' network meeting: Stigma in YPs' perspective // *Asian Journal of Psychiatry*.- Vol. 5 (2012) 208;
- Bezborodovs N., Krupchanka D., Butwicka A., Baessler F., Bendix M. Young Psychiatrists' Network: development of a forum for international collaboration // // 21th European Congress of Psychiatry, 6-9 April 2013, Nice, France. Abstracts on USB-stick;
- Krupchanka D., Bezborodovs N., Butwicka A., Bendix M., Baessler F., Paravaya O., Jauhar S., Hanson J. 3rd Young Psychiatrists' Network – EFPT Meeting "Stigma from the YPs' perspective: Hopes and Challenges" 27-29 September 2012, Minsk, Belarus // *WPA news*.- Sep. 2012;
- Paravaya O., Krupchanka D., Bezborodovs N., Dias M.C., Navadvorskaya M., Bendix M., Butwicka A. Discovering new horizons // *International Psychiatry*.- Vol. 10 (2013);
- Krupchanka D.A., Paravaya O.I., Kruk N.V., Bezborodovs N.S. 3rd Young Psychiatrists' Network– EFPT Meeting. «Stigma from the YPs' perspective: Hopes and Challenges»// *Psychiatry, Psychotherapy and Clinical Psychology*. №4(10), 2012. - P.6-16 2

2. Presentations:

Agnieszka Butwicka	Young Psychiatrists' Network Meetings – Moving together towards new horizons A. Butwicka, Department of Child Psychiatry, Public Paediatric Teaching Hospital, Warsaw (Poland) DGPPN German Psychiatric Congress Berlin, Germany 2011
Marie Bendix	Hur och varför kan ST-läkare engagera sig internationellt? Psychiatric Trainee Conference Varberg, Sweden, 2011
Marija Rusaka	Why do we need a Young Psychiatrists network? An example from Latvia M. Rusaka (Latvia); DGPPN German Psychiatric Congress Berlin, Germany 2011
Sameer Jauhar	Trainees research networks ... A European research, DGPPN German Psychiatric Congress Berlin, Germany 2011
Nikita Bezborodovs	Young Psychiatrists' Network: development of a forum for international collaboration, 21th European Congress of Psychiatry, Nice, France 2013

ABSTRACTS OF LECTURES AND WORKSHOPS

Abstracts of lectures

ECNP SUPPORTED TALK: 'RANDOMNESS AND CAUSALITY IN PSYCHIATRIC CLINICAL PRACTICE AND RESEARCH'

(abstract of a lecture on 4rd April, 2014, 11:15 – 12:15)

Michael Davidson MD

Professor and Chairman, Department of Psychiatry, Tel Aviv University,
Chief Editor European Neuropsychopharmacology, Tel Aviv, Israel

Medicine is a science of uncertainty and an art of probability said the famous internist William Osler. Decision making in an environment of uncertainty is the rule for many human activities (ex. financial investing, pharmaceutical R&D) and, for most specialties in the clinical practice of medicine. Ideally, we should be able to quantify by agreed upon measurement the benefits of treating heart arrhythmias, the harm of not treating it and the risk of treating but causing more harm than benefit. We like to do it with the help of hard outcome measures which are not clouded by personal value systems. This is also true for less dramatic conditions and for treatments with smaller effects sizes such as pain, nausea or pruritus.

Because psychiatric interventions have neither dramatic effects nor hard outcomes, to prove efficacy/benefit/harm/risk assessment at societal and at individual levels are more difficult to assess, yet assessment is not less essential. Regulatory agencies, health care providers and individual physicians are all struggling to address these issues.

How much weight to give evidence when it contrasts with personal experience? How vulnerable is the observant psychiatrist to generate for herself faulty feedback? How to handle good quality but opposing or uncertain evidence and how much uncertainty to share with the patient? Are NNT and NNH helpful in assessing risk and communicating it to the patient despite the fact that they measure different phenomena? Are we blinded by the glitter of numbers?

We need to address these dilemmas since they exist in every moment of our clinical practice. For example are the GI disturbances caused by cholinomimetics in AD patients justified despite the fact that benefits cannot be observed clinically or measured psychometrically in individual patients? Is addition of antipsychotics in AD to treat psychosis justified despite the fact that the benefit is questionable but there is a very small increased in risk of death? How much psychotropic is justified in affective disorders despite the fact that it is almost impossible to gather good effectiveness evidence? Is there a point where treatment refractory psychosis or depression should not be treated with medication? We all make 10 to 20 such decisions every day but we very rarely turn back to try to understand how we reached the decisions. Is it "scientific intuition" and if so can it be improved?

EXCELLENCE IN PSYCHIATRIC SERVICE: A PROGRAM FOR THE FUTURE

(abstract of a lecture on 3rd April, 2014, 12:00 – 13:00)

Wolfgang Gaebel, MD, PhD, Professor

Department of Psychiatry and Psychotherapy, Medical Faculty, Heinrich Heine University,
Düsseldorf, Germany

e-mail: wolfgang.gaebel@uni-duesseldorf.de

Psychiatry is always on the edge: Patients think that psychiatrists treat them with mind-changing drugs, politicians think that it is associated with dangerous patients and too much money going into healthcare, and young medical doctors think it is not a good specialty for an excellent career. So what can psychiatry as a specialty do to change its perception for the patients, politicians and physicians? One approach will be to show that psychiatry is an empathic, evidence-based, consumer-oriented, safe and effective way to help people with mental disorders in all stages of their mental illness – from prevention and early detection to crisis intervention, rehabilitation and long-term secondary prophylaxis. This will lead to increased trust in psychiatric services – a topic of a recent European Guidance of the European Psychiatric Association (EPA; Gaebel et al., 2014). To achieve these components of excellence in psychiatry, one needs to address all these aspects simultaneously in a holistic effort to change the way patients, stakeholders and medical experts view psychiatry as a medical specialty. Such an ambitious effort will only become feasible if a structured program for the future of psychiatry will be developed. One of the major points of interest for such a novel program will be the question of the excellence of psychiatric services, since psychiatric services are the contact points of patients, politicians and medical specialists from other medical specialties. While excellence is a loosely defined term, one of the ways of achieving excellence is to aspire the highest possible degree of quality of mental healthcare, and a European Guidance on the quality of mental healthcare services addresses just this issue (Gaebel et al., 2012). Another issue is the question of how progress in research on mental disorder can be more efficiently translated into therapeutic progress in psychiatry. The transfer “from lab to bedside” needs to be supported by special projects evaluating the available evidence and implementing the results in clinical practice – for example, community mental health services need to be introduced in many European countries. Finally, excellence in psychiatric services will also be related to the excellence of those working for such services. Here, issues of training in psychiatry arise, but also questions of how to attract the best medical students into the specialty. Peer support groups and “meet the expert” approaches may be necessary to increase the visibility of psychiatry as an excellent opportunity for a professional career, but more research into the motivations of young medical doctors to enter and stay in psychiatry may be necessary to better understand the mechanisms of recruiting and retaining young medical specialists in psychiatry.

References:

- Gaebel W, Becker T, Janssen B, Munk-Jorgensen P, Musalek M, Rössler W, Sommerlad K, Tansella M, Thornicroft G, Zielasek J; European Psychiatric Association. EPA guidance on the quality of mental health services. *Eur Psychiatry*. 2012 Feb;27(2):87-113.
- Gaebel W, Muijen M, Baumann AE, Bhugra D, Wasserman D, van der Gaag RJ, Heun R, Zielasek J.
- EPA guidance on building trust in mental health services. *Eur Psychiatry*. 2014 Feb; 29(2):83-100.

ART AND NEUROSCIENCE

(on evolutionary meaning of art and its neurobiological relevance).

(abstract of a lecture on 5th April, 2014, 12:45 – 13:00)

Cyril Höschl, Filip Španiel

Prague Psychiatric Centre & 3rd Faculty of Medicine, Charles University,
Prague, Czech Republic

Neurobiological hypothesis of the evolution of art suggests that it was the size of social groups what determined the development of the human frontal cortex. Social cohesion is accomplished by mutual grooming. The cohesion of groups of hominids larger than 100 individuals could not be secured enough by “face-to-face” grooming up to 20-30% of time available. More time, however, could not be allocated for grooming, because other, life-important activities would be dangerously shortened. Instead, an additional effective way to maintain the social cohesion had developed in forms of vocalizations and drumming, which can be understood as a “social grooming”. Here the direct line to singing and to language can be traced. (In the Czech language, for example, *drbat* means both to tattle and to tickle). The gene FOXP2, which occurred roughly 500-200 thousand years before the present, seems - together with the neo-cortex (social brain) and social grooming - to be a precondition for language development. Music and language employ to some extent identical brain structures. Play (both music and game) also activates mirror cells. Mirror neurons play important role in empathy and in a prediction of behaviour of others. Prediction of behaviour of others is a fundamental precondition of survival and represents a substantial selective advantage. “Useless” childish games, and adult gossip, as well as “barren” activities like music, singing, drumming, and dancing are altogether operations employing and training the life-saving mirror neuronal systems, which are essential for our ability of insight.

Art, sport, games and play have therefore crucial importance for the development of our abilities to empathise and to predict the behaviour of others, to recognize their emotions, to maintain social cohesion and therefore alliances, and last but not least of our capacity for self-reflection. Art and games thus represent a common condition for the development of language, “motions” and emotions. From the evolutionary perspective, as “coaches” of our capacity to predict they represent a substantial selective advantage.

References:

- Brown S et al. Music and language side by side in the brain: a PET study of the generation of melodies and sentences. *European J Neurosci*, 23, 2006: 2791–2803.
- Dunbar RIM. The social brain: mind, language, and society in evolutionary perspective. *Annu Rev Antropol* 2003; 32:163-181.

- *Iacoboni M et al. Cortical mechanisms of human imitation. Science 286, 1999: 2526–2528.*
- *Iacoboni M et al. Grasping the Intentions of Others with One's Own Mirror Neuron System. PloS Biology 3, 2005:529–535.*
- *Kawabata H, Zeki S. Neural Correlates of Beauty. J Neurophysiol. 2004; 91:1699-1705,.*
- *Koelsch S. Significance of Broca's area and ventral premotor cortex for music-syntax processing. Cortex 2006; 42:518-520.*
- *Lewis P. Musical minds. TRENDS in Cognitive Sciences, 6, 2002; 9: 364-366.*
- *Molnar-Szakacs I, Overy K. Music and mirror neurons: from motion to 'e'motion. SCAN, I, 2006: 235–241.*
- *Höschl C, Španiel F. Umění a (neuro)věda [in Czech]. Sanquis, 2008;56:46-49.*

FROM EYE MOVEMENTS TO MOOD STABILIZATION: THE ROLE OF TRAUMA IN BIPOLAR DISORDER

(abstract of a lecture on 5th April, 2014, 10:00 – 11:00)

Ramon Landin-Romero, MD

FIDMAG Research Foundation

Barcelona, Spain

Traumatic events and post-traumatic stress disorder (PTSD) are frequent in severe mental illness, both in initiation and worsening the course and outcome. Therefore, psychotherapeutic interventions for trauma are clinically important but have been rarely studied.

In this context, Eye Movement Desensitization and Reprocessing (EMDR) is now recommended as an effective treatment for traumatic memories. The evidence of the co-occurrence of traumatic events and severe mental disorders and its consequences will be reviewed.

Recent studies published in the field will be also presented, including a controlled, randomized pilot trial of EMDR in traumatized, sub-syndromal bipolar I and II patients, the so-called BET-study (Bipolar EMDR Trauma-study), providing evidence of the utility of EMDR in bipolar disorder, beyond its classical indication as a PTSD related treatment. Finally, the concept of large scale networks such as the Default Mode Network (DMN) will be explained and its shared dysfunction in bipolar disorder and PTSD discussed. During the workshop the basic concepts of dissociation in the context of the severe traumatization will be introduced. This will be also accompanied of practical examples and videos to illustrate both the classic symptoms and the intervention on dissociation in severe mental disorders.

FUNCTIONAL NEUROIMAGING AND EEG MONITORING IN EMDR TREATMENT

(abstract of a lecture on 5th April, 2014, 9:00 – 10:00)

Marco Pagani

Institute of Cognitive Sciences and Technologies – CNR

Rome, Italy

Neuroimaging studies conducted in PTSD patients who have undergone various psychological treatments have provided evidence of modifications in cerebral blood flow, neuronal volume and

density and, more recently, brain electric signal (electroencephalography, EEG). During the past 13 years a body of research has been carried out on humans to evaluate psychotherapies effectiveness, despite difficulties arising from methodological issues. Their neurobiological ground has been supported by studies showing a post-treatment reversal of the functional pre-treatment abnormalities. Eye Movement Desensitization and Reprocessing (EMDR) is an effective psychotherapy for psychological traumas. This study monitored by EEG the neurobiological changes occurring in clients before, during and after EMDR therapy. Forty clients, victims of psychological traumas were investigated at the first EMDR session (T0) and at the last one performed after processing the index trauma (T1). Comparisons were also made with the EEGs of 20 non-symptomatic controls undergoing one single EMDR session. Differences between T0 and T1 and between T0 and controls were evaluated. As compared to T0, EEG during EMDR at T1 showed in clients a significantly decreased activity in the frontal and orbitofrontal cortex and an increased activity in left fusiform gyrus and lingual gyrus and right temporal lobe and fusiform cortex as compared to controls. We monitored for the first time specific neuronal activations associated with EMDR therapy. In the largest group of psychologically traumatized clients investigated so far by EEG we demonstrated a shift of cortical electric activity from limbic cortex to temporo-occipital regions following EMDR. These findings, supported by the comparison with healthy individuals, suggest that brain cortical processing of the index trauma moves from areas with emotional valence when the clients are symptomatic to regions with an established cognitive and associative role after therapy. Processing of the traumatic events following successful EMDR therapy resulted in distinct neurobiological patterns of brain activations associated with a significant relieve from negative emotional experiences.

SPECIAL SESSION: ASSOCIATIONS OF YOUNG PSYCHIATRISTS

(Abstract of a session on 5th April, 2014, 14:30 – 15:30)

Olga Paravaya, MD

Head of Psychiatric Department,

Psychiatric Clinic of Minsk City, Belarus,

e-mail: olgaparavaya@gmail.com

There are a lot of different organizations supporting young psychiatrists and trainees in their professional development.

In every country there is a national association for trainees or section within the adult psychiatric association. They are united together in the European Federation of Psychiatric Trainees (EFPT).

At the same time big psychiatric associations have initiative groups of young specialist working on projects for early carrier professionals:

- Early Career Psychiatrists Committee (ECPC) in the European Psychiatric Association (EPA)
- Early Career Psychiatrists Council in the World Psychiatric Association
- Junior Members Advisory Panel (J-MAP) in the European College of Neuropsychopharmacology.

All these structures provide number of activities such as educational courses, scholarships, research opportunities, exchange programs and networking possibilities. Knowing goals and projects of young psychiatrists organization opens new horizons, gives options for professional development in mutual cooperation.

FUNCTIONAL MOVEMENT DISORDERS

(abstract of a lecture on 4th April, 2014, 9:15 – 10:15)

Jan Roth, Tereza Serranová

Department of Neurology and Center of Clinical Neuroscience, Charles University in Prague, 1st
Faculty of Medicine and General University Hospital
Prague, Czech Republic

Functional (psychogenic) movement disorders are frequently seen in neurology outpatient clinics. However, the underlying pathophysiology is still poorly understood and from the clinical perspective, there can be many uncertainties regarding the diagnosis and treatment. Functional movement disorders are clinically characterized by variability and inconsistency of the symptoms, which are incongruent with movement disorders known to be caused by organic neurological disease. Here we review the terminology, definitions, epidemiology and typical presentations of the functional movement disorders and their individual forms and the clinical diagnostic criteria. Furthermore, we review advances in our knowledge of the pathophysiology that have questioned the formerly emphasized causal role of psychological factors, and suggested a neurobiological model of the development of symptoms. Diagnosis of functional movement disorders should rely on the presence of characteristic clinical features and not only on the exclusion of an organic cause. The early diagnosis and its acceptance by the patient, is crucial for the prognosis. The management of the functional movement disorders involves a multimodal approach with a dominant role of the neurologist, who establishes and communicates the diagnosis and guides the treatment.

RESEARCH AND MENTAL HEALTH CARE: ISSUES, CHALLENGES AND BENEFITS

(Abstract of a lecture on 3rd April, 2014, 9:30 – 10:30)

Norman Sartorius

Professor, President

Association for the Improvement of Mental Health Programmes (AMH); Geneva, Switzerland

e-mail: sartorius@normansartorius.com

In highly industrialized and rich countries a significant proportion of people with mental disorders does not receive mental health care. In low and even in middle income countries the situation is worse: there a vast majority of patients suffering from severe mental illness - for which there is an effective treatment - do not have access to mental health services. In many instances this is due to a lack of resources which is, in turn, to a large extent due to the stigma attached to mental illness. What makes things worse is that the services which are available often do not function as well as they could. New and better treatments would undoubtedly help: but even if they were to be invented soon their wide scale application would take a long time.

Many of the above problems could be resolved by better knowledge and research focused on the provision of mental health care is therefore an essential component of mental health programmes. Since resources for research are not endless it is necessary to decide which topics and methods of search will be given priority. The presentation will discuss how this can be done, what problems may arise in the process of doing so and what ways can be used to overcome them.

FAMILY EXPERIENCE OF MENTAL ILL HEALTH

(Abstract of a lecture on 5th April, 2014, 11:30 – 12:45)

John Saunders

EUFAMI treasurer and Board member, SHINE director

e-mail: jsaunders@shineonline.ie, www.shineonline.ie; www.recover.ie, www.eufami.org/

This presentation will focus on the experience of families when an individual has a severe mental health problem. Issues explored will include diagnosis, Accessing services, families and service providers, the burden of care, family roles in recovery, social stigma and public awareness.

EUFAMI was founded in 1992 after a congress, which took place in 1990 in De Haan, Belgium, where carers from all over Europe shared their experiences of helplessness and frustration when living with severe mental illness. They resolved to work together to help both themselves and the people they cared for.

EUFAMI is a democratic organisation, registered in Belgium as an international non-profit organisation. We have an ongoing commitment to improving care and welfare for people affected

by mental illness. We also enable our member organisations to act jointly at a European level, combining their efforts and sharing experience.

GLOBAL MENTAL HEALTH

(Abstract of a lecture on 3rd April, 2014, 10:30 – 11:30)

Graham Thornicroft, MD, PhD, Professor

Centre for Global Mental Health

Institute of Psychiatry, King's College London,

London, United Kingdom

e-mail: graham.thornicroft@kcl.ac.uk www.iop.kcl.ac.uk

There is an emerging consensus that the transfer of knowledge from proven biomedical discoveries into patient and public benefit should be accelerated. At the same time there is a little conceptual clarity either about the precise nature of the phases of this 'translational continuum', or about the proper place within it of 'implementation science. This paper will address these issues by using the example of the WHO mhGAP Implementation Guidelines for Low and Middle Income countries with reference to: (i) an integrated schema to understand the whole translational medicine continuum, consisting of five sequential phases; (ii) discussing the nature of three important blocks between these phases; and (iii) considering the place of implementation science within this continuum, and (iv) addressing solutions that have been identified worldwide to the common barriers that limit putting evidence into policy and practice.

References

- Thornicroft G, Tansella M. *Better Mental Health Care*. Cambridge: Cambridge University Press; 2009.
- Tansella M, Thornicroft G. *Implementation science: understanding the translation of evidence into practice*. *Br J Psychiatry* 2009; 195(4):283-285.
- Thornicroft G, Tansella M, Law A. *Steps, challenges and lessons in developing community mental health care*. *World Psychiatry* 2008; 7(2):87-92.
- Thornicroft G, Alem A, Atunes dos Santos R, Barley E, Drake R, Gregorio F et al. *WPA guidance on steps, obstacles and mistakes to avoid in the implementation of community mental health care*. *World Psychiatry* 2010; 9:67-77.
- Barbui C, Dua T, van Ommeren M, Yasamy M, Fleischmann A, Clark N, et al. *Challenges in Developing Evidence-Based Recommendations Using the GRADE Approach: The Case of Mental, Neurological, and Substance Use Disorders*. *PLoS Medicine* 2010;7(8):e1000322.
- Hanlon C, Wondimagegn D, Alem A. *Lessons learned in developing community mental health care in Africa*. *World Psychiatry* 2010 Oct;9(3):185-9.
- World Health Organization. *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: (mhGAP)*. Geneva: WHO; 2010.
- Dua T, Barbui C, Clark N, Fleischmann A, van Ommeren M, Poznyak V, et al. *Evidence based guidelines for mental, neurological and substance use disorders in low- and middle-income countries: summary of WHO recommendations*. *PLoS Medicine* 2011;8:1-11.
- Chatterjee S., Naik S., John D., Dabholkar H., Balaji M., Koschorke M., Varghese M., Thara R., Weiss H. A., Williams P., McCrone P., Patel V., and Thornicroft G. *Cost-effectiveness of a community based intervention for people with schizophrenia and their caregivers in India: the COPSI randomised controlled trial*. *The Lancet* (in press)

Abstracts of workshops

WORKSHOP SESSION: "MY PSYCHIATRY"

Jerker Hanson ass. professor, MD, PhD, Dmitry Krupchanka MD

e-mail: dmitry.krupchanka@gmail.com

Introduction: "Quot homines tot sententiæ" (many men, many minds) (Terence). Difference of perspectives appears not only on the basis of specialty but rather is a property of uniqueness of human being. Sometimes it creates a ground for controversies but on the other hand enrich the world of visions by rising diversity. Sharing opinions and discussion of ideas is the way to new ones. The session will be focused on sharing and discussing perspectives of well-known professionals regarding their experience of being a psychiatrist and visions toward present and a future of discipline.

Aim: A workshop with a personal touch. Questions and discussions about difficult problems and conflicts are welcome.

Material and Methods: Personal experiences, material and comments from participants. The session will be started by short speeches of 4 invited speakers: Professor Wolfgang Gaebel, Professor Jerker Hanson, Professor Wolfgang Rutz, Professor Norman Sartorius. The other part will be devoted to facilitating discussion both between speakers and audience of young psychiatrists.

The main ideas of invited speakers are covered in 4 abstracts below:

1. My psychiatry (reflections for a workshop at the 4th meeting of young psychiatrists), Professor Jerker Hanson
2. This is my Psychiatry (reflections on preconditions and selection mechanisms of timely psychiatry and psychiatrists), Professor Wolfgang Rutz,
3. My Psychiatry (a personal history in psychiatry and a vision of the future), Professor Wolfgang Gaebel,
4. My psychiatry, Professor Norman Sartorius.

MY PSYCHIATRY

(reflections for a workshop at the 4th meeting of young psychiatrists)

Jerker Hanson, ass. professor, MD, PhD

Stockholm, Sweden.

e-mail: jerker.hanson@telia.com

Personal background/JH: A multidimensional, partly advanced education (basic and clinical neurophysiology, clinical work in many different medical specialties, psychotherapy, assistant professor at Karolinska Institute) gave me a lot of choices for my career.

I finally chose psychiatry because I saw needs and possibilities and that there was a place for me.

After some years I understood that if I want to make a change for patients I had to work with changes in organizations and with activities in society. I got a chance to be become a chief of a psychiatric clinic which I was glad to take. First thing was to form a management group to help me to good decisions - I'll never forget the open minded support from them. I had a paper on my door where we put items for the agenda. It was good to know that after the meeting on Friday we would have chosen a solution that I could take.

I liked the national and county council agenda for development of psychiatric care around 1975 – 1995 - moving out from old mental hospitals, patient friendly care... But we had to formulate concrete goals and encourage staff to choose how they could plan and work in the direction we wanted. In this planning we had a lot of brain storming meetings with consultants, head nurses, psychologists etc, also with help from some very good professional management advisors. We had to collaborate with other organizations working with our patients – that is in Sweden mainly social services and family medicine. That gave us a broad and stimulating field for our activities.

At 65 I had to retire from my position. I became a psychiatrist again for 10 years in an outpatient unit for long-term mentally ill, together with social service – a wonderful experience also.

My conclusions: Psychiatry gives better possibilities for fruitful work than other medical specialties. But you have to learn a lot about psychiatry, society, management, economy, conflicts, group dynamics, yourself. You have to adapt to others' demands without sacrificing too much of your own ambitions. International/historical perspectives help.

With patients, you have mainly to cling to the perspectives of the patient. It is a challenge to forget for a moment all the things that you think are rational and necessary.

In management it is important to have explicit goals – training helps. Doctors are important but might be difficult to manage. Connections outside the clinic necessary for discussing personal matters.

References:

- Hanson J. "Nya mål, flera dimensioner, action. Åtklämning av Bengt Berggrens psykiatriska korv." *Svensk Psykiatri*, Nr 3, 2013 *Varför blev du psykiater?* pp 32-33 (Sw)

- *Mario, M. "Keeping an open attitude towards the RDoC project". http://www.wpanet.org/uploads/Publications/WPA_Journals/World_Psychiatry/Past_Issues/English/World%20Psychiatry_February%202014.pdf*

THIS IS MY PSYCHIATRY.

(reflections on preconditions and selection mechanisms of timely psychiatry and psychiatrists)

Wolfgang Rutz , MD, PhD, Professor

Regional Advisor Mental Health, WHO Europe (retired), Past President, Swedish Society for Biological Psychiatry, Past Vice President, Swedish Psychiatric Association

University for Applied Sciences, Coburg/Germany

Senior Consultant,

Stockholm, Sweden

Psychiatry today has after some decades of psychodynamic and psychoanalytically influenced reductionism suddenly turned to be as reductionist in a contrary way, however extremely instrumental, medicalised , categorizing and disease oriented, facilitated by quantitative assessments, often static diagnostical systems , guidelines and symptom orientation..

The author advocates the need for a psychiatric renaissance, that integrates both body and mind, works person centered and not only disease orientated, and thus again tries to biodynamically, synoptically and holistically integrate humanistic and natural scientific aspects on peoples life and their human condition. Psychiatry is thus to be seen as the science of the #Conditio humana#, in a way that neither solely humanistic oriented nor solely biological oriented experts are capable to grasp. This psychiatry should see its role and obligation in bridging qualitative and humanistic science as well as human beings measurable biological conditions into a holistic unity, a psychiatry that even scientifically makes a clear distinction between causality and correlation and that redefines evidence towards an integration of both qualitative and quantitative aspects on humans life. This psychiatry should and could willingly and self-confident accept its role / both as a protagonist in the frontline of a necessary development in the medical world, where today the need for more humanized approaches in general is badly felt, but also as an expertise on human ecology, providing advice and analysis to society and its political and other decision makers.

In this workshop aspects of recruiting psychiatrists and encouraging this kind of psychiatric identity will be discussed and problematized.

References:

- *Eisenberg Leon. Mindlessness and Brainlessness in Psychiatry. Brit.J. of Psych. 148, 1986, 148, 497 / 508.*
- *Maj Mario. Are Psychiatrists an endangered species. World Psych. 2010, February 9.1. ½.*
- *Rutz Wolfgang. Rethinking Mental Health. An European WHO Perspective. World Psych. 2003 June 2. 2, 125 / 127.*

MY PSYCHIATRY
(a personal history in psychiatry and a vision of the future).

Wolfgang Gaebel, MD

Professor of Psychiatry and Psychotherapy, Dept. of Psychiatry and Psychotherapy, Heinrich Heine University, Düsseldorf, Germany

My personal history in psychiatry started in Berlin more than thirty years ago – social psychiatry was the topic of that era and the culmination was a thorough reform of German mental healthcare services: more out-patient care and more psychiatric departments in general hospitals shaped the picture. As this development was going on, I was trained in psychiatry, psychotherapy and – a German peculiarity – neurology, which continues to be a mandatory part of psychiatry specialist training in Germany up to this day. Having obtained the necessary board certifications and following a brief research fellowship in Canada, I took over my current position as the department head of a large psychiatric department in Düsseldorf in 1992. My way since then can be described as a constant challenge to balance scientific, clinical and management interests and demands on time – with the added spice of a considerable personal involvement in national and international psychiatric associations, motivated by the personal impression that German psychiatry could greatly profit from a new openness towards world psychiatry. My personal view of psychiatry has changed much in the last 20 years – we have seen fascinating technological developments in neuroimaging, genetics, therapy, all of which were successfully used in research on mental disorders shaping our view of mental disorders as biopsychosocial constructs. This makes psychiatrists the generalists in medicine par excellence – we need to address the biological, psychological and social aspects of mental illness in patient care, diagnosis, treatment, classification, teaching and research, forming a holistic picture of the person with a mental disorder, who is still – and who should always stay - at the centre of our professional aspirations.

Psychiatry as a medical specialty faces several challenges which need to be addressed with a view to find ways into a better future for our patients: One challenge is the vanishing art of psychopathology, which we need to put back into the centre of our clinical teachings. Another challenge is the elucidation of the complex aetiopathology of mental disorders – we are just beginning to understand how the different biopsychosocial factors interact in the individual leading to the clinical appearance of a mental disorder. A third challenge is the ascertainment of evidence based, high-quality, safe and efficient mental healthcare for all in need – which puts psychiatry in a competition with other specialties for clinical and research budgets, and which opens a global perspective resulting in the need to find ways of safe and efficient mental healthcare in low-resource countries. A fourth challenge which became virulent during the recent discussions about the revised classification systems of mental disorders is whether and – if so - how to integrate novel

research findings into the classification criteria, a challenge which leads also to urgent questions about the conceptualization of mental disorders, and – methodologically - how to arrive at conclusions about such pressing questions. The answer will also bear on the trust which patients, politicians and the public will have in psychiatry and psychiatrists as competent partners in healthcare. This brings up a final challenge related to the picture of psychiatry in the public and among medical students and young medical doctors: How can we convey the picture of psychiatry as a fascinating medical specialty, and how can we attract and retain the best students and young doctors to take up a professional career in psychiatry, to ascertain a competent and empathic future workforce for the mentally ill?

References

- Gaebel W, Muijen M, Baumann AE, Bhugra D, Wasserman D, van der Gaag RJ, Heun R, Zielasek J. EPA guidance on building trust in mental health services. *Eur Psychiatry*. 2014 Feb;29(2):83-100.
- Mayer S, van der Gaag RJ, Dom G, Wassermann D, Gaebel W, Falkai P, Schüle C. European Psychiatric Association (EPA) guidance on post-graduate psychiatric training in Europe. *Eur Psychiatry*. 2014 Feb;29(2):101-6.
- Gaebel W, Zielasek J, Cleveland HR. Classifying psychosis--challenges and opportunities. *Int Rev Psychiatry*. 2012 Dec;24(6):538-48.
- Bhugra D, Gaebel W, Zielasek J. State of psychiatry in Europe. *Int Rev Psychiatry*. 2012 Aug;24(4):273
- Gaebel W, Zielasek J. From genes to mental representations: a comment to "why schizophrenia genetics needs epigenetics". *Psychiatr Danub*. 2012 Mar;24(1):28-30.
- Gaebel W, Zäske H, Cleveland HR, Zielasek J, Stuart H, Arboleda-Florez J, Akiyama T, Gureje O, Jorge MR, Kastrup M, Suzuki Y, Tasman A, Sartorius N. Measuring the stigma of psychiatry and psychiatrists: development of a questionnaire. *Eur Arch Psychiatry Clin Neurosci*. 2011 Nov;261 Suppl 2:S119-23.
- Gaebel W, Zielasek J. Integrative etiopathogenetic models of psychotic disorders: methods, evidence and concepts. *Schizophr Bull*. 2011 Sep;37 Suppl 2:S5-12.
- Gaebel W, Zielasek J, Cleveland H. Psychiatry as a medical specialty: challenges and opportunities. *World Psychiatr* 2010; 9: 36-38.
- Sartorius N, Gaebel W, Cleveland HR, Stuart H, Akiyama T, Arboleda-Flòrez J, Baumann AE, Gureje O, Jorge MR, Kastrup M, Suzuki Y, Tasman A (2010): WPA guidance on how to combat stigmatization of psychiatry and psychiatrists. *World Psychiatry* 9(3): 131–144.

MY PSYCHIATRY
Norman Sartorius,
 Professor, President

Association for the Improvement of Mental Health Programmes (AMH)
 Geneva, Switzerland

e-mail: sartorius@normansartorius.com

The presentation that I expect will precede discussion will briefly discuss the reasons for entering into postgraduate training in psychiatry and describe the development of my career and thinking about psychiatry in years that followed.

WORKSHOP SESSION: THE PROJECT TO FACE STIGMA OF MENTAL DISORDERS

«KONSTIGMA»

Marie Bendix MD, Dmitry Krupchanka MD

e-mail: marie.bendix@me.com

Background. “Art is not, as the metaphysicians say, the manifestation of some mysterious idea of beauty or God; it is not, as the aesthetic physiologists say, a game in which man lets off his excess of stored-up energy; it is not the expression of man’s emotions by external signs; it is not the production of pleasing objects; and, above all, it is not pleasure. It is a means of union among men, joining them together in the same feelings, and it is indispensable for life and progress toward the well-being of individuals and of humanity.” Leo Tolstoy, in his essay “What Is Art?”

Summary. The konStigma project aims to lower stigma of patients with mental illness by raising awareness about mental illness in the public and by raising self-efficacy through economic gain. This is achieved by the interactive exhibition of art and the provision of an economic system to sell the exhibits. KonStigma project is an anti-stigma intervention (which geographical regions?). The first goal is to lower stigmatization of patients with mental illness. The second goal is to raise self-efficacy and self-esteem by letting artists sell their exhibits to a buyer of their choice. As konStigma is a project connected to YPSnet with a board consisting of international psychiatrists it also is a project that enhances exchange of knowledge and experiences among psychiatrists and it is a continuation of prior YPSnet activities.

Goal and aims of a session: the authors describe the above project and will open discussion among YP on how better to conduct it. We will also look forward to people interested in its implementation.

WORKSHOP SESSION: PSYCHOANALYTIC PERSPECTIVE OF SPLITS IN
CONSCIOUSNESS AND PERCEPTION OF LOSS OF CONTROL CREATING ‘FALSE’

ANXIETY

Salise Kocak

Seniour Lecturer, Psychology Department

The American University

Nicosia, Cyprus

With the growth of technological advancements, communication systems and individual structure of communication (individual and collective level) are reformulated. Understanding levels of communication systems and the effects of these structures on the individual psyche requires interdisciplinary focus. Virtual environment research for example, shows how experience in virtual space creates a space for reconstruction of identities and it also distances individuals from daily

stresses, social norms and provides a break from daily personas (Pederson, 1997). It also may increase anxiety, in particular with social media users. This would mean analysing processes of experience and perception from different perspectives. The author aims to provide interdisciplinary perspectives on communication systems and conscious perceptions to define experience. Anxiety and manipulation of consciousness are key focus areas.

Anxiety has long been associated with increased unconscious processing of threat and biased attention focus towards threat stimuli (Ruderman & Lamy, 2012). This means that anxiety is created as a result of direct perception of threat or when faced with stimuli associated with past experience of a threat. Since unconscious processing is involved in associations of anxiety and how these code into the unconscious, to effect conscious perception of events/stimuli via communication needs to be considered. This can be achieved via analysing different theoretical frameworks (social cognition, psychoanalytic theory, cognitive psychology and clinical psychology research). Diminished perception of control over events can also be discussed as creating a sense of unpredictability and reduced control and this introduce a limited sense of control over ones environment and hence the self increased susceptibility to anxiety-related distress (Barlow et al, 1996; cited in Brown, White, Forsyth & Barlow, 2004).

To conclude, different perspectives to manipulation of consciousness in communication and experience of anxiety (and 'false' anxiety) through perception of loss of control will be discussed with relevance to future interdisciplinary research.

Key words: Communication, conscious/ unconscious perception, manipulation, anxiety, cognition, perception of control.

WORKSHOP SESSION: OPEN DIALOGUE

Michał Kłapciński, MD, PhD student

Department of Psychiatry, Division of Consultation Psychiatry and Neuroscience

Wrocław, Poland

e-mail: michal.klapcinski@gmail.com

In Finnish Western Lapland the „Open Dialogue“ [OD] Approach for the treatment of psychosis has been successfully implemented for more than 25years. It integrates designing meticulous, need-adapted treatment plan for each case with specific vulnerability on dialogical processes present among patient's network. At its core lie Tom Andersen's idea of reflecting processes, special attention on dialogicality, tolerance of uncertainty and polyphony of voices. Practice orientated workshop will help deepen the understanding of the effectiveness of the approach.

WORKSHOP SESSION: GENDER DYSPHORIA IN SWEDEN - THE ROLE OF THE
EVALUATING TEAM

Kyriaki Kosidou, MD

Stockholm County Council/Karolinska Institute

Stockholm, Sweden

e-mail: kkosidou@gmail.com

There are different definitions of gender that may or may not be concordant. Gender dysphoria refers to the distress that is caused by a discrepancy between a person's gender identity and the person's legal sex as assigned at birth, the associated gender role and primary and secondary sex characteristics. If Gender Dysphoria causes significant distress it becomes a diagnosis: Transsexualism (ICD10), Gender Identity Disorder (DSM4), Gender Dysphoria (DSM5). Gender dysphoria is a rare condition but prevalence rates are rising all over the world according to recent reports. In Sweden, there are six gender teams for evaluation and treatment of persons with gender dysphoria, in Alingsås (Gothenburg), Linköping, Lund, Stockholm, Umeå, and Uppsala. Each team consists of psychiatrists, psychologists and social workers. Persons that seek treatment for gender dysphoria are evaluated in the multidisciplinary team. Treatment is subsidized by the Swedish social security system after a diagnosis is made. Treatment options for female-to-male persons include cross sex hormonal treatment, vocal treatment, mastectomy, penis prosthesis. Male-to-female persons are treated with cross sex hormonal treatment, hair removal, wig, alteration of laryngeal framework and vocal cords. The treated persons are then encouraged to real life experience i.e. to live and present in the desired gender role on a day to day basis, across all setting in life. After at least two years of observation, including one year in real life, the person applies to The Legal Board of The National Board of Health and Welfare, for a new legal status in the new gender, including a new personal identification number, and for permission to do sex reassignment surgery (SRS). A certificate from the Gender team is attached.

WORKSHOP SESSION: ANTYPsYCHIATRY

Dmitry Krupchanka, MD

Stockholm County Council/Karolinska Institute

Stockholm, Sweden

e-mail: kkosidou@gmail.com

The session will be devoted to considering main concepts of antypsychiatric movements: R.D.Laing, F.Basalia, D.Kuper, T. Szasz, M.Facault. The slow development of some concepts and thoughts of antypsychiatry seems to brought about their hidden integration into current ideas of modern psychiatry. The comparison with articles of CRPD will be made.

The main question that will be put under consideration: How can we differentiate radical and useless thoughts against psychiatry from useful criticism that should be listened and integrated in future development of mental health care system?

WORKSHOP SESSION: TRAUMA AND DISSOCIATION WORKSHOP

(identification and treatment of dissociative disorders in Lithuania)

Jonas Mikaliūnas, MD

Vilnius, Lithuania

e-mail: jonas.mikaliunas@gmail.com

Most of the time, during my psychiatric residency at Vilnius University (2009-2013), I worked in inpatient psychiatric unit. There were many patients diagnosed with schizophrenia, depression, some manic patients. There were many patients who had problems with addiction to alcohol. Many patients in Lithuania get into psychiatric inpatient after a suicide attempt. Sometimes there were neurotic patients with conversion disorders. The emphasis in residency was put on pharmacological treatment of patients, although there was some psychological psychiatry and very little of social psychiatry paradigm. There was almost no theoretical or practical training about identification and treatment of Dissociative Disorders.

Luckily I had a chance to do a residency in Australia, where Dr. David Leonard introduced me with Dissociative Disorders (DID). He has worked with DID patients for many years. He suggested me to read a textbook about the Theory of Structural Dissociation (van der Hart O, Nijenhuis E, Steele K, 2006), where authors talk about three levels of structural dissociation of the personality:

1. Primary, which includes simple Post Traumatic Stress Disorders (PTSD), and simple Dissociative Disorders;
2. Secondary, which includes chronic, complex PTSD, Borderline Personality Disorder, and Dissociative Disorders not Otherwise Specified;
3. Tertiary, which include Dissociative Identity Disorder (DID, DSM-4) or Multiple Personality Disorder (ICD-10).

Now, working as psychiatrist in inpatient ward, I find this theory and guidelines (Guidelines for Treating DID, 2011) useful, when I meet seriously psychologically traumatized patients. I like the idea of diagnostic and treatment continuum of such disorders: from Phase 1 - Establishing Safety, Stabilization, and Symptom Reduction (what we usually do in inpatient psychiatric unit), to Phase 2 – Confronting, Working Through, and Integrating Traumatic Memories, and Phase 3 – Integration and Rehabilitation.

I am trying to share this theory with young colleagues in my country and hope someday there will be a branch of European Society for Trauma and Dissociation (ESTD) in Lithuania as well.

References:

- *Van der Hart O, Nijenhuis E, Steele K. (2006) The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization. New York, London.*
- *International Society for the Study of Trauma and Dissociation (2011): Guidelines for Treating Dissociative Identity Disorder in Adults, Third Revision, Journal of Trauma & Dissociation, 12:2, 115-187.*

WORKSHOP SESSION: PSYCHOSOCIAL REHABILITATION IMPORTANCE AND
DEVELOPMENT IN THE TREATMENT OF MENTAL DISORDERS

Eugenijus Mikaliūnas, MD

Director of Psychiatric Clinic of Republican Siauliai Hospital,
Siauliai, Lithuania

The main methods used in treating patients with severe mental illnesses are as follows: psychopharmacotherapy, psychotherapy, and psycho-social rehabilitation. The first two methods are known and widely used in Lithuania; meanwhile psychosocial rehabilitation is understood ambiguously. The paper provides information available in scientific literature and practical examples of psychosocial rehabilitation services offered in the psychiatric clinic of Republican Siauliai Hospital.

Keywords: psychosocial rehabilitation, functioning, international classification of functioning, disability and health (ICF), psychosocial rehabilitation models and methods, rehabilitation methods, community-based rehabilitation, self-help groups, the methods to reach professional goals, services activities description, recovery.

Psychosocial rehabilitation description

According to the World Health Organization (WHO, 1995), Psychosocial rehabilitation is: "a process that facilitates the opportunity for individuals – who are impaired, disabled or handicapped by a mental disorder – to reach their optimal level of independent functioning in the community". It implies both improving individual's competencies - skills and introducing environmental changes in order to create the best possible quality of life for people who have experienced a mental disorder, or who have an impairment of their mental capacity which produces a certain level of disability.

The overall goal of psychiatric rehabilitation is to assure that the person with psychiatric disability can perform those physical, emotional, social and intellectual skills needed to live, learn, work and socialize in the community with the least amount of support necessary from helping professions (Anthony, 1979).

Restoring persons with psychiatric disabilities to optimal states of constructive activity depends on a person's mental health's "stage of recovery" – person's ability to cope with the disease and disability, and his or her self-image as a functioning person.

Psychosocial rehabilitation is a complex process composed of assessment (at the symptomatic, functional and resource levels), planning (the persons and the persons environment needed skills

and resources) and intervention (provide services to gain needed skills and supportive environment).

Psychiatric rehabilitation services are collaborative, person – directed, individualized and should be evidence – based. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning and social environment of their choice. (The United States Psychiatric Rehabilitation Association - USpra, 2007).

The major methods by which the mission of psychosocial rehabilitation is accomplished involve either developing the specific skills the person needs to function effectively and/or developing the supports needed to strengthen the person’s present levels of functioning (Anthony, 1979; Anthony, Cohen & Cohen, 1983; Liberman & Fox, 1983). Usually intervention techniques can cover social skills training (connecting with others), daily life tasks (budget planning, preparing food, personal hygiene skills, home care tasks), leisure time planning (find out interest) and so on.

Nowadays a growing body of evidence reveals that pharmacological methods of treatment only suppress symptoms of disorder, while rehabilitation helps to minimize impairment and to optimize everyday quality of life. Patients may then regain pleasure in life, get able to live successfully in their environment and also develop their individual capacities and skills.

References:

1. Anthony W, Cohen M, Farkas M. *Psychiatric rehabilitation*. 1994.
2. Carlos W Pratt, Kenneth J Gill, Nora M Barrett, Melissa M Roberts. *Psychiatric Rehabilitation. Third Edition*. 2014.
3. *The best Lithuania’s mental health care programs*. 2000.
4. Goštautaitė Midtun N. *Community-based psychosocial rehabilitation. Psychiatric news No. 1*. 2001.
5. Kriščiūnas A and et al. *Rehabilitation*. 1993.
6. *Modules for training social and independent living skills. Psychiatric Rehabilitation Consultants: www.psychrehab.com*.
7. Mueser KT, Bond GR, Drake RE. *Community- Based Treatment of Schizophrenia and Other Severe Mental Disorders: Treatment Outcomes*. Medscape. 2001.
8. *Psychiatry*. Vilnius. 2003.
9. Sartorius N, De Gironimo G, Andrews G, German GA, Eisenberg L. *Treatment of mental disorders*. 1993.
10. *The International Classification of Impairment, Activity, and Participation, ICDH-2*. Vilnius. 1999.
11. *ICD-10 mental and behavioral disorders: clinical and diagnostic*. 1997.
12. Weeghel J. *Community care and psychiatric rehabilitation for persons with serious mental illness*. 2002.

ABSTRACTS OF PARTICIPANTS

PSYCHOLOGICAL FEATURES OF SOCIAL POSITION OF PATIENTS WITH PSORIASIS

**Belugina O.S.³, MD, Siatkovskij V. A.², MD, PhD, Azarova L.A.², MD, PhD, Belugina I.N.¹,
MD, PhD, Jagovdik N.Z.¹, MD, PhD**

¹Belarusian state medical university,

²State Institute of Management and Social Technologies of the Belarusian State University,

³Republican Research and Practice Centre for Mental Health

Minsk, Belarus

Psoriasis one of the most frequently registered chronic dermatosis.

Aims: To investigate features of social maladjustment and mechanisms of psychological defence in patients with psoriasis.

Materials and methods: We examined 76 patients with psoriasis. 67 patients with skin lesions and 9 - with skin lesions and joint damage. Man – 45, woman – 31. Control group – 42 people without skin and joint pathology. For assessment of social maladjustment and psychological defence in patients with psoriasis were used valid tests, adapted to our population: visual analogue scale that contain 8 of main parameters of assessment of quality of life and Life Style Index.

The results of the research were statistically processed with usage of Students t-criterion for the independent sample and for Mann — Whitney U-test.

Results and discussion: It is appeared that quality of life in common to be the most problematic in patients with psoriasis in comparison with people in control group ($60,3 \pm 3,2$ and $73,8 \pm 2,3$, $p < 0,001$) which first of all correlates with such formal medical parameter as “skin condition” ($44,8 \pm 2,8$ and $83,0 \pm 1,9$, $p < 0,001$) and paramount parameter of patients social wellbeing - “interaction between spouse” ($73,7 \pm 4,5$ and $87,8 \pm 2,3$, $p < 0,01$).

The most significant decrease in these parameters occurred in patients with arthropathic form of psoriasis ($p < 0,001$). Burdened and unburdened family history in the development and course of the disease has a definite impact on the parameters of quality of life of patients.

Scale study of the features of the ego-protection in patients with psoriasis that include such classic mechanisms of psychological defense of personality such as 1-negation, 2-suppression, 3-regression, 4-compensation, 5-projection, 6-substitution, 7-intellectualization, 8 - jet formation also revealed significant differences between the studied parameters in patients with psoriasis compared with those in the control group.

Patients with psoriasis in order to improve their socio-psychological adaptation unconsciously more often use most of the methods of psychological defence (7 of 8, except intellectualization).

The most significant changes, especially in the parameters regression and projection observed in patients with arthropathic form of psoriasis ($p < 0.01$).

Less use of this form of psychological protection as intellectualization, which in patients with arthropathic form of psoriasis was statistically significant compared to controls ($40,2 \pm 6,0$ and $63,5 \pm 3,4$, $p < 0,01$).

Analysis of the results obtained by the method of LSI individually for each of the subjects allowed to note that there are significant differences in psychological defense mechanisms between men and women, both in healthy individuals and patients with psoriasis.

Results and discussion

1. Psychodiagnostics of psychological defense mechanisms of personality is important when considering the direction and methods of individual psychotherapy in patients with psoriasis in the combined treatment of dermatosis.
2. Family therapy is an important aspect of psychotherapeutic care for patients with psoriasis.

MENTAL ILLNESS IN SWEDEN: A COIN WITH MANY SIDES

Marie Bendix, MD; Jerker Hanson, MD, PhD; Kyriaki Kosidou, MD, PhD; Anastasia Poyiadji, MD; Johan Reutfors, MD, PhD; Wolfgang Rutz, MD, PhD; Myrto Sklivanioti, MD; Henrik Wahlberg, MD

Stockholm and Södertälje, Sweden.

e-mail: jerker.hanson@telia.com

Aim: To give an overview concerning the knowledge about prevalence, treatment, management and treatment of mental illness in Sweden.

Material and Methods: From personal knowledge, data files and websites.

Results: Mental processes and illnesses are nowadays in Sweden often considered to be phenomena coming from the brain or the genes that can be visualized and measured. However, patient's complaints and functional impairments are still to be found in other spheres and remain everyday challenges for clinicians.

Investigations show large, unidentified and unmet needs in the population - especially in immigrants, elderly and youths. In 2013, nearly one every ten teenagers sought psychiatric care in Stockholm County. This can mirror an increased prevalence of mental ill-health, reduced stigma for mental illness and/or an increased help-seeking behaviour and illustrates the importance of mental illness in Swedish public health.

In Sweden, responsibility for health care including mental health is divided between three authorities: 21 counties, 290 municipalities and national authorities. Private services are increasing as is the importance of patient organizations.

The mantra of "Evidence based psychiatry" is often seen as the king in developing and controlling the services – but how do individual experiences and preferences of patients and therapists count?

Statistics from trials are important to identify effective treatments for groups of patients. However, there is no guarantee that the same treatment will be effective for each individual patient. Placebo treatment is obviously a very effective treatment (“evidence based”) - but how to use in an ethically acceptable way?

The mental health services in Sweden are still much focused on traditional hospital care. There is a huge lack of prevention, rehabilitation and recovery programs.

The dominant media images of people with mental illness are perceived to consolidate public prejudice and stereotypes. Recurrent stigmatization correlates with poor psychosocial functioning, frequent admissions to inpatient care, low self-esteem, and subjective poor quality of life. Patients want adequate information about their illness from the staff they want more self-control over their care and treatment.

Conclusions: Mental illness, treatment and care in Sweden is a challenge!

References:

1. Höye A. Time for new thinking on psychiatric diagnosis. *The Nordic Psychiatrist* 2013; 2:8-11
2. http://www.wpanet.org/uploads/Publications/WPA_Journals/World_Psychiatry/Past_Issues/English/World%20Psychiatry_February%202014.pdf
3. <http://www.hjarnkoll.se/In-English>

NEUROANATOMY AND NEUROPHYSIOLOGY OF ANXIETY DISORDERS IN DEVELOPMENTAL AGE

Agnieszka Dąbkowska

Psychiatry Clinic Hospital, Poznan, Poland

Objective. The purpose of the study is to summarize recent publications pertaining to changes in neuroanatomy and neurophysiology of anxiety disorders in developmental age.

Method. This paper reviews the latest publications describing changes in neuroanatomy and neurophysiology in children and adolescents with anxiety disorders. General anxiety disorder, social phobia, separation anxiety disorder, obsessive-compulsive disorder and post-traumatic stress disorder were taken under consideration. Both structural and functional MRI studies were considered.

Results. Some studies point enhanced amygdala activity in anxious adults and both anxious and shy children and adolescents. Amygdala activity is correlated with intensity of anxiety. Surprisingly, it was shown enhanced activity of prefrontal cortex among children with general anxiety disorder, social phobia and separational anxiety disorder. This result was in opposite to the hypothesis based on the fact of increase of activity of prefrontal cortex and emotional control because of age. Results of these studies lead to question whether enhanced activity of amygdala in anxiety disorders is caused by amygdala’s poor inhibition or increased activity of prefrontal cortex.

There are correlations between intensity of compulsions and obsessions and activity of nucleus accumbens and superior parietal lobe; as well as between intensity of compulsions and activity of anterior cingulate cortex. Some kinds of treatments causes functional changes in brain, for example insula and putamen activity decrease after 6-month therapy with fluoxetine; normalization of regional blood flow in caudum, dorsolateral prefrontal cortex and anterior cingulate cortex after 12-week therapy with paroxetine; diminish of the left amygdala after SSRI therapy.

According to post-traumatic stress disorder, results of functional and structural MRI are inconsistent. Some studies point enhanced activity of amygdala, ACC, insula, medial prefrontal cortex, ventrolateral prefrontal cortex and hippocampus. Other papers described diminished activity of dorsolateral prefrontal cortex and hippocampus. Some structural studies conclude in changes in corpus callosum, insula, amygdala, medial prefrontal cortex, whole brain volume; other describe no changes in frontal lobe, amygdala and hippocampus. In groups of abused children with post-traumatic stress disorder, reduced volume of the brain and of the mediosagittal area of the corpus callosum and increased lateral ventricle, as well as reduced cerebellar volume, but no changes in pituitary gland were found.

Conclusions. More studies are needed, to define significance of changes in neuroimaging in anxiety disorders.

ON THE USE OF SUMMARY STATISTICS AND COMPUTATIONAL MODELS FOR BEHAVIOURAL DATA ANALYSIS

Jaroslav Drapala¹, Dorota Frydecka²

¹Faculty of Computer Science and Management, Wroclaw University of Technology,

²Department of Psychiatry, Wroclaw Medical University; Wroclaw, Poland

Analysis of behavioural data typically involves regression of physiological data versus summary statistics obtained from the data. The more advanced approach is to use computational models that are mathematical formulations of hypothesis concerning physiology of the learning process. Parameters of computational models allowed to fit the model to particular subject and values of those parameters may be further used to perform advanced statistical analysis and inference. Reversal learning, probabilistic learning and instructional learning tasks are examples of sources of behavioural data. Reinforcement learning models are one of the most frequent computational models. Maximum likelihood and Bayesian estimates of model's parameters are used to summarize behavioural data.

We propose to include agent-based models to analyze behavioural data. An agent represents some strategy that may be followed by a subject playing the learning task. Agents provide reference

points, allowing to classify subjects and to assign strategy followed by the subject. We show results of an analysis performed on a group of 41 subjects playing Reversal Learning Task.

AUTISM SPECTRUM DISORDERS AS A POST-TRAUMATIC DEVELOPMENTAL DISORDER

Paulina Golaska, PhD student

Adam Mickiewicz University, Department of Educational Studies,
Poznań, Poland; e-mail: paulinagolaska@o2.pl

Autism Spectrum Disorders (ASD) are a phenomenon receiving increasing attention of researchers, therapists and young parents. Currently treated as a complex disorder with the severity of symptoms lying on a spectrum, it was first recognized by Leo Kanner in children who were not able to maintain emotional connection with others. The less severe state of autism, Asperger's Syndrome, described first by Hans Asperger, is now better understood as a high-functioning form of autistic disorder and was included in the DSM-V Autistic Spectrum Disorders category. There are many ways of understanding ASD symptoms, and there are different perspectives on its causes and treatment. In the dynamic paradigm autistic states are thought to be the result of a process of coping with severe psychobiological or biopsychological trauma which the child is not able to undergo without any external help. This process is similar to the one in adults who experience traumatic stress but with a crucial difference – it has a total impact on a not structured yet child's personality. Because of having no sufficient strategies to cope with such overwhelming stress, the child's psyche becomes very fragile to every stimulus which is felt as a threat now. To protect him/herself from an absolute disintegration, the child starts to encapsulate and withdraw from external reality. Hypersensitivity, especially in reaction to others whose unpredictability and emotionality are thought to be the most stressful stimuli, makes the child not able to learn from experience and to develop his/her own personality. The aim of this poster is to present the process of encapsulation as well as to describe the Autistic Spectrum Disorder as a Post Traumatic Developmental Disorder. The author will include a short description of some of the most well-known dynamic theories of autism and indications for the psychotherapy of children with ASD.

MORTALITY IN SCHIZOPHRENIA: REVIEW OF EUROPEAN LITERATURE FROM RECENT YEARS

Tomasz M. Gondek, Anna Królicka, Andrzej Kiejna, Patryk Piotrowski

Department of Psychiatry, Wrocław Medical University, Poland
e-mail: gondektm@gmail.com

Schizophrenia is a chronic disease with mortality rate significantly higher than in general

population for both natural and unnatural causes. In recent years in Central and Eastern Europe no papers regarding this topic were published internationally.

The aim of this paper was to determine in which European countries mortality in schizophrenia was researched, what methods were used, how causes of death in schizophrenia changed over time and an attempt to possibly answer why papers about schizophrenia mortality have not been written in Central and Eastern Europe.

The PubMed database was searched for English-written papers published in years 2009-2013 regarding mortality in schizophrenia in European countries. From 40 results 25 were found useful. No papers from Central and Eastern Europe met the criteria. Only in Great Britain, Denmark, Finland and Sweden studies regarding this topic were published in English during the last 5 years.

Mortality rate for persons suffering from schizophrenia is higher than in general population, with natural causes dominating over unnatural ones. In the second half of 20th century chronic diseases - circulatory system diseases and tumours - became causes of most deaths in population of people with schizophrenia, with suicides remaining the most frequent unnatural cause of death. Mortality gap and the risk of premature death rise for people suffering from schizophrenia. Also life expectancy for this group is significantly shorter in comparison to general population.

Data registers containing information about diagnoses, used treatment and deaths of mentally ill persons are pivotal tools in mortality studies. No favourable trends in schizophrenia mortality were found in Western European publications from the last 5 years. SMR rate remained constant or slightly rose, especially in case of deaths from natural causes.

TWO FACES OF POLYUNSATURATED FATTY ACIDS IN DEMENTIA

**Grzegorz Herbinger, Tomasz Wysoczanski, Ewa Sokola-Wysoczanska, Kaja Sokola,
Andrzej Vogt**

Research and Development Department of Lumina Cordis Foundation.

Omega – 6 fatty acids have a detrimental effect in dementia especially if consumed in large amounts in western diet. Arachidonic acid (AA) is the most active omega -6 fatty acid. It causes intracellular acidosis and uncouples oxidative phosphorylation, triggering oxidative stress. 4-hydroxynonenal – product of nonenzymatic oxidation of AA inhibits sodium-potassium pumps and over activates NMDA receptors. Reactive oxygen species and AA activate nuclear factor NF-kB, which increases production of proinflammatory cytokines.

All of the above reactions are mediated by AA and called the Arachidonic cascade. Metabolites of AA have strong proinflammatory properties. Prostaglandin E (PGE₂) induces strong activity of gamma secretase and accumulation of amyloid beta. Omega-6 fatty acids increase inflammation and oxidative stress in neurodegenerative conditions.

The Human body, however has internal defence mechanisms mediated by omega-3 fatty acids and their metabolites. DHA and EPA inhibit cellular signals of AA release from glicerophospholipids, which stops the arachidonic cascade. EPA is incorporated into mitochondrial lipid membranes and reduces mitochondrial potential, which stops cytochrome c release.

EPA and DHA metabolites, the so called resolvines E and D series (E-from EPA metabolites, D-DHA metabolites), neuroprotectin D1 (NPD1) and maresins have very powerful anti-inflammatory properties, inhibiting infiltration of polymorphonuclear lymphocytes and increasing macrophage-mediated phagocytosis. These two steps are crucial for termination of the inflammatory response.

Omega -3 fatty acids metabolites act as biochemical safety break, which keeps inflammation in control and stop long term and over-expressed inflammatory responses.

Omega -3 fatty acids and their metabolites inhibit microglial activity and hence having strong neuroprotective actions. They reduce accumulation of amyloid beta through activation of alpha secretase and inhibition of beta and gamma secretases.

Omega 3 fatty acids and their metabolites inhibit proapoptotic signals and the neurotoxicity of amyloid beta as well as kinases phosphorylating Tau protein.

Neuroprotectin D1 inhibits ROS mediated activation of caspase 3, hence having powerful neuroprotective activity during oxidative stress. It reduces activity of COX-2, which is highly expressed in Alzheimer's disease.

DHA triggers the expression of L11 protein (ApoE receptor), which reduces transfer of the beta amyloid protein precursor to the site, where secretases are active.

Omega-3 fatty acids enhance expression of IGF-1, CREB and BDNF, which have powerful neuroprotective action. They increase insulin signalling and insulin sensitivity. Considering that Alzheimer's disease is a form of insulin resistance in the central nervous system (type 3 diabetes) such action might be of significance.

Isolated resistance to IGF-1 and IGF-2 has been observed in Dementia with Lewy Bodies and omega -3 fatty acids may play a role here.

Omega -3 fatty acids reduce dyskinesias significantly after long term treatment with L-DOPA and protect against MPTP (1-methyl-4-phenyl-1,2,3,6 tetrahydropyridine).

L-DOPA elevates levels of arachidonic acid in patients with Parkinson's disease and concentrations of this acid correlate with severity of dyskinesias.

It seems that our bodies crave omega -3 fatty acids, because enzymes synthesizing neuroprotectin D1 are highly elevated in Alzheimer's disease. All we have to do is take advantage of this.

References:

- „Hot Topics in Neural Membrane Lipidology” Akhlaq A. Farooqui.
- „Phytochemicals, Signal Transduction, and Neurological Disorders” Akhlaq A. Farooqui.
- „Beneficial Effect of Fish Oil on Human Brain” Akhlaq A. Farooqui.
- „Lipid Mediators and Their Metabolism in the Brain” Ahhlaq A. Farooqui.

- “Metabolic syndrome” Akhlaq A. Farooqui.
- “Metabolic syndrome and neurological disorders” Akhlaq Farooqui.

OPEN DIALOGUE APPROACH, ABOUT THE PHENOMENON OF FINNISH PSYCHIATRY

Michał Kłapciński, MD, PhD student

Department of Psychiatry, Division of Consultation Psychiatry and Neuroscience

Wrocław, Poland

e-mail: michal.klapcinski@gmail.com

In Finnish Western Lapland, the schizophrenia incidence rate dropped from 35/100 000 in the beginning of the 80s to 7/100 000 in the mid 90s during a twenty-year transformation period of mental health care [1,2]. This phenomenon is linked with Yrjö O. Alanen et al. who investigated schizophrenia treatment outcomes within the frame of the Turku Project. The investigators' main interest was on psychosocial rehabilitation and individually tailored psychotherapeutic recovery plans during a patient's hospitalization. Encouraged by the promising results of therapeutic approaches towards psychotic patients researchers conducted the Finnish National Schizophrenia Project between 1981-87. Throughout this time, the principles of the Need-Adapted Treatment were created and 50% of Finland's country gained access to mobile crisis intervention teams [3]. Further study was continued within the Acute Psychosis Integrated Treatment Project 1992-93 which, in Western Lapland, proceeded into Open Dialogue in Acute Psychosis Project. As a result Open Dialogue [OD] approach emerged. OD concentrates on network oriented meetings where important subjects regarding the patient, including hospitalization or pharmacotherapy, are discussed. Two and five-year follow-ups demonstrated high treatment efficacy as well as important cost reduction in mental health care spending [4-6]. In Poland since September 2013 two OD training programs are being conducted, with 54 attendants.

References

1. Lehtinen V, Taipale V. Integrating mental health services: the Finnish experience. *International Journal of Integrated Care*. 2001; Vol. 1
2. Aaltonen J, Seikkula J, Lehtinen K. The Comprehensive Open-Dialogue Approach in Western Lapland: I. The incidence of non-affective psychosis and prodromal states. *Psychosis*. 2011; 3(3): 179-191
3. Tuori T, Lehtinen V, Hakkarainen A, Jääskeläinen J, Kokkol A, Ojanen M i współ. The Finnish National Schizophrenia Project 1981-1987: 10-year evaluation of its results. *Acta Psychiatrica Scandinavica*. 1998; 97: 10-17
4. Alanen YO. Towards a more humanistic psychiatry: Development of need-adapted treatment of schizophrenia group psychoses. *Psychosis: Psychological, Social and Integrative Approaches*. 1(2):156-166.
5. Seikkula J, Alakare B, Aaltonen J. The Comprehensive Open-Dialogue Approach in Western Lapland: II. Long-term stability of acute psychosis outcomes in advanced community care. *Psychosis*. 2011; 1-11
6. Seikkula J, Aaltonen J, Alakare B, Haarakangas K, Keränen J, Lehtinen K. Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies. *Psychotherapy Research*. 2006; 16(2): 214-228.

PSYCHOLOGICAL TREATMENT IN SCHIZOPHRENIA - NEEDS AND CHALLENGES

Ewa Klosińska

Psychiatric Day Hospital, Autonomous Public Clinical Hospital No. 1

Wroclaw, Poland

e-mail: ewa.klosinska@gmail.com

Recent research shows the need to include the impacts of self-stigma, metacognition, and narrative as a form of diagnosis and therapy in psychological treatment in schizophrenia.

Metacognition is the ability to think about one's own thinking and the thinking of others. Self-stigma (SS) is creating its own identity associated with the experience of mental illness in relation to the stereotypical perceptions of mental illness by society. The GEMIAN-Europe study shows that SS is found in most people with schizophrenia (Brohan et al., 2010). It causes low self-esteem, low empowerment, less social contact, and affects the hope. It also affects a sense of social force, quality of life, belief in the responsibility for the appearance of the disease, belief in the possibility of recovery. Research shows that these constructs can affect each other. The ability to use metacognitions to solve daily challenges does not affect the thinking about oneself as a person likely to cause embarrassment, and thus being less liked (Lysaker et al, 2011). This also demonstrates the strength and stability of SS. What affects the SS is ability to establish and maintain relationships with others, i.e. a sense of social power (Campellone et al, 2014). Work on understanding and predicting the thought processes of others (metacognition) is a therapeutic target associated with the formation of the relationships, or social force (Dimaggio et al, 2013). Stronger SS and weaker metacognition affect the narrative of the disease. This narrative is less developed, although it protected person before the experience of the disease. Therefore, working on insight and improving SS and metacognition can prevent depressed mood (Lysaker et al., 2008). Therapeutic programs referring to SS are effective in the reduction of SS and reinforce insight (Yanos et al., 2012).

The next challenge is naming or changing the name for schizophrenia (Tranulis et al., 2013). We say: schizophrenics, people with experience of mental illness, the mentally ill, people with the mental crises. Do we call schizophrenia a disease or a syndrome? Is it possible to recover from schizophrenia, or can only be in remission? What is the impact of metacognition?

The names we use are related to SS. The Open Dialogue Approach, effective in people who have appeared the first symptoms of psychosis is based on understanding the symptoms, and speaking about them without naming them. This in turn protects against SS, facilitates acceptance and changes (Seikkula, et al., 2003). Similarly, individual therapy can focus on understanding the symptoms without naming them. An important question for future studies is how to call the symptoms during group activities, such as psychoeducation. What naming will not strengthen SS

but at the same time help to achieve insight, and thereby minimize symptoms, and return to social life. What kind of narration helps build, what to say to others? Future research is needed.

References

1. Brohan, E., Elgie, R., Sartorius, N., & Thornicroft, G. (2010). *Self-stigma, empowerment and perceived discrimination among people with schizophrenia in 14 European countries: the GAMIAN-Europe study*. *Schizophrenia Research*, 122(1-3), 232–8. doi:10.1016/j.schres.2010.02.1065
2. Lysaker, P. H., Erickson, M., Ringer, J., Buck, K. D., Semerari, A., Carcione, A., & Dimaggio, G. (2011). *Metacognition in schizophrenia: the relationship of mastery to coping, insight, self-esteem, social anxiety, and various facets of neurocognition*. *The British Journal of Clinical Psychology / the British Psychological Society*, 50(4), 412–24. doi:10.1111/j.2044-8260.2010.02003.x
3. Campellone, T. R., Caponigro, J. M., & Kring, A. M. (2014). *The power to resist: The relationship between power, stigma, and negative symptoms in schizophrenia*. *Psychiatry Research*, 215(2), 280–5. doi:10.1016/j.psychres.2013.11.020
4. Dimaggio, G., Popolo, R., Salvatore, G., & Lysaker, P. H. (2013). *Mentalizing in schizophrenia is more than just solving theory of mind tasks*. *Frontiers in Psychology*, 4(February), 83. doi:10.3389/fpsyg.2013.00083
5. Lysaker, P. H., Buck, K. D., Taylor, A. C., & Roe, D. (2008). *Associations of metacognition and internalized stigma with quantitative assessments of self-experience in narratives of schizophrenia*, 157, 31–38. doi:10.1016/j.psychres.2007.04.023
6. Yanos, P. T., Roe, D., West, M. L., Smith, S. M., & Lysaker, P. H. (2012). *Group-based treatment for internalized stigma among persons with severe mental illness: findings from a randomized controlled trial*. *Psychological Services*, 9(3), 248–58. doi:10.1037/a0028048
7. Tranulis, C., Lecomte, T., El-Khoury, B., Lavarenne, A., & Brodeur-Côté, D. (2013). *Changing the name of schizophrenia: patient perspectives and implications for DSM-V*. *PloS One*, 8(2), e55998. doi:10.1371/journal.pone.0055998
8. Seikkula, J., Alakare, B., Jukka A., Juha H., Ville L., Anu R. (2003). *Open Dialogue Approach : Treatment Principles and Preliminary Results of a Two- year Follow-up on First Episode Schizophrenia*, 5(3), 163–182.

A PATIENT WITH PARANOID SCHIZOPHRENIA AND RECURRENT NONCARDIOGENIC PULMONARY EDEMA – A CASE REPORT.

Weronika Korzyńska¹, Tomasz M. Gondek², Anna Skoczyńska¹

¹ Department and Clinic of Internal and Occupational Diseases and Hypertension, Wrocław Medical University,

² Department of Psychiatry, Wrocław Medical University,
Wrocław, Poland

A 32-year-old woman with paranoid schizophrenia, treated with high-dose risperidone and clozapine, valproic acid and benzodiazepines, was transported to the emergency department with a diagnosis of recurrent noncardiogenic pulmonary oedema. Echocardiography previously ruled out left ventricle dysfunction.

On admission, the patient gave a coherent verbal response, was cardiovascularly and respiratorily stable with blood pressure of 130/60 mmHg and stable sinus rhythm of 100 bpm, normal heart axis on electrocardiography. Basic laboratory tests revealed elevated white blood cell count of 12000/μl and slightly elevated D-dimer value. Chest X-ray showed normal middle shadow and no pulmonary focal lesions.

Physical examination demonstrated a generalized muscle tremor, muscular rigidity, in lungs crepitations up to the inferior angles of the scapulae and single dry rales. In the first hours of hospitalization a cardiopulmonary destabilization occurred with blood pressure decrease to 80/40

mmHg, massive dry rales and coarse rales in lungs, pulmonary oedema with foaming at mouth and drop in blood saturation. Extrapyrarnidal rigidity in the axial muscles, plastic muscle tone in the limbs, muscle tremor, ocular bradykinesia and disorders of consciousness were observed. Additional blood tests showed elevated creatine kinase, high level of benzodizepines and a decreased iron level.

On the basis of clinical symptoms and additional tests, a recurrent pulmonary oedema in the course of neuroleptic malignant syndrome, drug-induced extrapyramidal syndrome and benzodiazepine intoxication, was diagnosed.

During the hospitalization, antipsychotics and benzodiazepines were discontinued, the infusion of catecholamines was maintained, patient was aspirated and hydrated, which resulted in stabilization of vital functions. Cardiovascularly and respiratorily stable, without pulmonary oedema, the patient was transferred to the psychiatric ward for further treatment.

GENETIC AWARENESS IN PSYCHIATRIC PRACTISE

Maja Krefft, MD, PhD student,

Wroclaw Medical University, Department of Psychiatry,

Wroclaw, Poland

e-mail: maja.krefft@gmail.com

Many studies of genetic syndromes aim to investigate psychiatric symptoms as well as cognitive and behavioural profiles. Some of these symptoms are common in normally developing children like elimination disorder, whereas some are more specific and unique, like skin picking or temper outbursts. Intellectual disability (ID), often presents in diseases with a genetic background, and has an adverse impact on social functioning and adaptive behaviours in affected patients. Therefore, the patient with ID in psychiatric practice should arouse psychiatrists' genetic vigilance and lead to directing to a genetic specialist. Moreover mental retardation isn't the only symptom taken under consideration. Other behavioural and emotional problems such as externalizing (e.g. hyperactivity, oppositional and conduct disorder) and internalising (e.g. depression, anxiety, phobias) disorders are inherent parts of many genetic syndromes. Some of them are highly rare, while others such as Down Syndrome, Turner Syndrome, Rett Syndrome, Fragile-X Syndrome, Prader-Willi Syndrome, Williams Syndrome, Tuberosc Sclerosis, CHARGE Syndrome, Hall-Hittner Syndrome Angelman Syndrome, Cornelia de Lange, Cri-du-chat, Lesh-Nyhan Syndrome and Smith-Magenis Syndrome are widely known for their psychiatric components. Maintaining genetic awareness allows us to predict the occurrence of some symptoms characteristic of genetic disorder, prevent the

development of illness and set up proper treatment. So if psychiatry is your currency remember that this coin has a genetic side.

WHEN TO SUSPECT PRADER-WILLI SYNDROME IN PSYCHIATRIC PATIENTS

Maja Krefft, MD, PhD student,

Wroclaw Medical University, Department of Psychiatry,

Wroclaw, Poland

e-mail: maja.krefft@gmail.com

Prader-Willi Syndrome (PWS) is a complex and multisystem genetic disorder characterized by physiological, physical and psychological symptoms. PWS is usually associated with morbidly obese patients. However, today the increased awareness of this genetic condition has led to the identification of behavioural phenotypes as the more relevant process when making a diagnosis and establishing a proper treatment. Therefore, it is essential to remember to include a particular set of symptoms within the medical interview while examining the patient specifically noting skin picking, insistence on sameness, temper tantrums or mood fluctuations. Besides these maladaptive behaviours such as compulsions and rituals, some case reports also present psychosis among patients, higher levels of depression, autistic behaviours, ADHD symptoms, bipolar and pervasive developmental disorders. Interestingly, there are marked differences between the symptoms presented in the genetic subtypes of PWS which are related to the creation of the disorder (deletion in the paternal chromosome or maternal uniparental disomy). As obesity can be controlled externally by diet restrictions, psychiatric management of the described symptoms is important for both recognizing new cases and treating affected patients.

REWARD AND PUNISHMENT LEARNING IN SCHIZOPHRENIA AND BIPOLAR DISORDER: EXPERIMENTAL AND COMPUTATIONAL DATA

Ahmed Moustafa

School of Social Sciences and Psychology and Marcs Institute for Brain and Behavior,

University of Western Sydney

We tested reward and punishment learning in four patient groups: those with schizophrenia, bipolar disorder with psychosis, bipolar disorder without psychosis, and healthy controls. We also used computational actor-critic models to fit behavioural data to better understand the information processing mechanism underlying learning performance. Experimental results show that patients with schizophrenia and bipolar disorder with psychosis were more impaired at reward learning than patients with bipolar disorder without psychosis and healthy controls. Computational analysis

shows that learning rate parameter in the critic (rather than the actor) better explains the behavioural results. These findings offer a neurocomputational account of the nature of psychotic behaviours in schizophrenia and bipolar disorder.

MINOR PSYCHIATRIC ILLNESS OF CLIMACTERIUM: INVOLUTIONAL HYSTERIA
(CONCEPTIONS, TYPOLOGY AND PSYCHOSOMATIC RELATIONS)

Tatiana Polyakovskaya

Moscow Research Institute of Psychiatry,

Moscow, Russian Federation,

e-mail: yanta@inbox.ru

In present report evolution of views on the problem of Involutional Hysteria is regarded, from its separation as independent disorder to abolishment of notion of «Climacteric Neurosis» and its «solution» in different categories of ICD-10 and DSM –IV. Contemporary conceptions of minor psychiatric illness of climacterium are closely considered. In our study these disorders are conceptualized as psychosomatic disorders. Our sample includes 85 women (average age - $49,1 \pm 5.22$ years). Typology developed in our study is based on clinical variety of conditions, named Involutional Hysteria (IH). Two variants of IH are identified. I type (55 cases) – Somatized Hysteria - is characterized by prevalence of conversions, organo-neurotical and hypochondriacal symptoms in clinical sign. Basic tendency of dynamics – persistency in the form of hystero-hypochondriac development, accompanied by amalgamation of bodily sensations with deviations of personality, appropriate to oppressed masochists (Millon Th., 1996). II type (30 cases) - Hysteroid Disphoria – is characterized by hysterical depression in the form of «reaction of disappointment» and includes hypothymia inseparable from dissociative symptoms, reflecting «key experience», and dysphoric outbursts. Phenomena of «la belle indifference» contrasts with hypochondria in the clinical signs of Somatized Hysteria. The dynamics are characterized by gradual reduction of symptoms, developed in the form of the prolonged depressive phase, provoked by psychogenic triggers.

Keywords: Involutional Hysteria; Somatized Hysteria; Hysteroid Disphoria; minor psychiatric illness of climacterium; conceptions; psychosomatic disorders.

MOOD-STABILIZING MEDICATION AFTER HOSPITALIZATION FOR BIPOLAR
DISORDER IN SWEDEN

**Johan Reutfors¹, Jari Tiihonen³, Louise Scheen¹, Lena Brandt¹, Antti Tanskanen³,
Morten Andersen¹, Robert Bodén^{1,2}**

¹Centre for Pharmacoepidemiology, Department of Medicine Solna, Karolinska Institutet,
Stockholm, Sweden

²Department of Neuroscience, Psychiatry, Uppsala University, Uppsala, Sweden

³Department of Clinical Neuroscience, Karolinska Institutet, Stockholm, Sweden
Stockholm, Sweden

e-mail: johan.reutfors@ki.se

Aim: To investigate the utilization patterns of mood stabilizers (MS) in the first month after hospitalization for bipolar disorder (BD).

Methods: Patients with a diagnosis of BD (ICD-10 codes F30.0 – F31.9) in Sweden between July 1, 2006 and December 31, 2011 were identified in the National Patient Register, from which data on previous psychiatric hospitalizations was also extracted. Drug dispensing data was obtained from the Prescribed Drug Register. A run-in period of one year prior to diagnosis was used to exclude prevalent users of Mood Stabilizers (MS, i.e. lithium, antipsychotics, and anticonvulsants with an indication for the treatment of BD). The patients were followed for 30 days post discharge regarding MS dispensing. The patients were censored at death.

Results: There were 6 030 unique hospitalizations of patients with BD who were not prevalent users of MS. The median age of these patients was 47 years (range 10 to 104 years), 3 581 (59%) were women, and 2 828 (47%) had a previous diagnosis of BD. The proportion of patients with no dispensing of a MS within the first month after hospitalization was 43%, whereas 35% were dispensed one, 19% were dispensed two, and 3.5% were dispensed three or more different MS.

Overall, the proportion of patients who were dispensed lithium was 18.8%, antipsychotics 38.4%, and anticonvulsants 21.8%. The proportion of patients who were dispensed lithium only was 8.1%, an antipsychotic only 19.1%, and an anticonvulsant only 9.8%. A concomitant dispensing of lithium and an antipsychotic or an anticonvulsant was found in 7.3% and 0.9% of the patients, respectively. A concomitant dispensing of an anticonvulsant and an antipsychotic was found in 8.5%.

Conclusions: Our results suggest that among patients with BD with no recent use of a MS, just more than half of the patients are dispensed a MS in the first month after hospitalization. Among patients with BD who do use a MS, the majority are dispensed antipsychotics, although this is not usually considered a first-line treatment in the maintenance phase.

DIAGNOSIS AND MANAGEMENT OF CATATONIA

Eglė Biliūtė Rodinienė, Edgaras Dlugauskas, Vita Danilevičiūtė

Vilnius University Faculty of Medicine Psychiatry Clinic

Vilnius, Lithuania

e-mail: egggle@gmail.com

Catatonia syndrome is a psychomotor movement disorder, with the coexistence of psychic and motor symptoms: it can occur as excitement or muscular rigidity, suppression of movements, even stupor. German Dr. Karl Ludwig Kahlbaum first named and described catatonia in his monograph in 1874. He selected the term catatonia to describe „tension insanity“ and held that the neuromotor signs (e.g., waxy flexibility) were more important than the content of delusions (e.g. megalomania). While K. L. Kahlbaum was convinced that he was describing a unitary illness, he identified mood disturbances, psychosis and medical conditions occurring in this syndrome. Kraepelin included catatonia as belonging to the group of dementia praecox, but acknowledged that catatonic symptoms may occur in different psychiatric disorders.

Catatonia may occur as a separate syndrome in patients who have psychiatric, neurologic, or other medical conditions. Catatonic patients may experience movement disorders: stupor or excitement, negativism, waxy flexibility, muscle rigidity, stereotipic movements, echopraxia, automatic obedience. Mutism, echolalia, verbigeration, grimacing, social detachment, urinary incontinence, refusal to eat and drink. According to different authors, catatonia is diagnosed from 7 to 17% of acutely ill psychiatric patients. Catatonic symptoms may be subtle. If not treated timely, catatonia can lead to lethal medical complications (acute renal failure, thromboembolism, gastrointestinal bleeding, myocardial infarction, pneumonia) and death of the patient. It is important to diagnose catatonia in a timely manner, differentiate potential causes of the syndrome, and start effective treatment strategies.

TOPOLOGY OF THE PERSON

Bartłomiej Skowron

Chairman of the Academy of Young Scholars and Artists

Wrocław, Poland

The study is to show how some basic topological concepts can be used to express some basic properties of the person. Topology is a branch of mathematics. It is a far-reaching generalization of geometry; it is the analysis of location and forms of situation of specific objects in specific spaces. Kurt Lewin's book titled Principles of topological psychology (1936) serves as a main source of that kind of “mathematical thinking” in psychology and philosophy of the person. The person is understood as a highly differentiated region in the life space. Different parts of the person are

related to each other, the state of one part could be influenced by the state of another. This creates a dynamic structure of the person, which can be described (represented) in a specific way by the topology. The main point of the paper is to clarify and identify the specificity of this representation.

WHAT ARE THE CONSEQUENCES OF USING NEUROPSYCHOLOGICAL METHODS BY PSYCHIATRIST?

Zofia Śliwińska MA, PhD student

County hospital in Zgorzelec, University of Social sciences and humanities,
Wroclaw, Poland, e-mail: zosia.sliwinska@interia.pl

Key words: Mini Mental Test (MMSE), functional diagnosis, psychometric characteristics

One of the professional tasks of each psychologist should be a functional diagnosis. It consists of examination of disordered functions, and its result is a presentation of the patient's functioning in specific cognitive areas. This procedure is similar to a "miniaturized" experimental study, because it requires the investigator to define a problem, pose and verify the hypothesis, generalize the results and draw conclusions for practice -- so-called recommendations.

Each testing method must be characterized by parameters such as: appropriateness, reliability, normalization, standardization and objectivity. Using only such tests one can be sure that the method is reliable. What's more, using psychological tools not knowing those parameters, one may make a false diagnosis.

Widely available to psychiatrists, some of psychological methods are distributed without any data about the test. The most common test: the MMSE (Mini-Mental) and CDT (Clock Drawing Test), usually are available to the doctors only as test sheets, with a brief description of the scoring, although the MMSE has a full manual with descriptions of psychometric parameters.

Methods without mentioned values cannot be called a test, therefore planning further treatment based on such scores, can bring very negative consequences for the patient such as untimely or unjustified diagnosis of dementia.

More favorable would be to refer the patient for neuropsychological examination made by a psychologist, i.e. to a specialist with wider range of reliable methods to assess neuropsychological functioning.

References:

1. Barczak A., Gorzkowska A., Klimkowicz-Mrowiec A. (2012), *Ocena zaburzeń funkcjonowania poznawczego*, W: *Diagnostyka i leczenie otępień. Rekomendacje zespołu ekspertów Polskiego Towarzystwa Alzheimerowskiego*, Otwock: Medisfera
2. Brzeziński J. (2007), *Metodologia badań psychologicznych*, Warszawa: Wyd. Naukowe PWN
3. Folstein M., Folstein S., Fanjiang G. (2009), *MINIMENTAL - Krótka Skala Oceny Stanu Umysłowego (MMSE)*, Warszawa: Pracownia Testów Psychologicznych
4. Gabryelewicz T. (2003), *Łagodne zaburzenia poznawcze. Rozpoznawanie, różnicowanie i postępowanie*, Warszawa: Med Media
5. Pąchalska M. (2007), *Nuropsychologia kliniczna. Urazy mózgu, procesy poznawcze i emocjonalne*, Warszawa: Wyd. Naukowe PWN

CREATIVITY AND PSYCHOPATHOLOGY

Kaja Sokola

University of Social Sciences and Humanities

The object of interest presented in this work is the relationship between creativity and psychopathology. According to the dictionary of psychology, creativity is a creative attitude and mental process leading to the creation of new ideas, concepts, associations and links with already existing ideas and concepts. Creative thinking is thinking leading to the original solutions.

Creativity is the generation of ideas and behaviours, original and useful ones, and putting them into practice. The possibility of creation of new, socially useful and influential ideas is combined with the creativity of eminent writers, philosophers and scientists. Creative people are characterized by a broad interest, fascination with complex problems, high vigor, confidence and ability to deal with contradictions.

Like in the science, there is no one specific definition of creativity, so the psychology does not have any standard technique to measure it. Possible links between psychopathology and creativity were already developed in the time of Plato. Aristotle wrote "Problemata", in which he described the frequent occurrence of melancholy in the life of eminent people living in those times. Numerous modern scientists are currently dealing with this relationship, focusing their attention on the origins, course, and genetic predisposition leading to this correlation.

Cesare Lambroso (Italian psychiatrist, anthropologist and criminologist) was the first researcher looking for the relationships between above-average abilities and mental illness. He pointed to a combination of genius, a variety of mental disorders and the tendency to addiction. Moreover, he observed that such tendencies often coexisted in the families of the outstanding people. The relationship is also observed in people with mood disorders, especially with bipolar personality and psychotic thinking.

AM Ludwig (1998) and F Post (1994) studied how degrees of psychopathology varies depending on the kind of creativity. Risk for mental diseases may be considerably higher degree in artists than in scientists. Analysing the relationship of these two dependencies, we can find both pros and cons of artistic creativity. The pros can include high emotional intelligence, a strong ego and an ability to adapt to change. Negatives are: bipolar affective disorder, severe depression and suicides.

The research of LL Heston was devoted to the development of various forms of creativity in relatives of people with schizophrenia. He found that adopted children whose mothers suffered from schizophrenia had higher artistic skills.

NC Andreas described that the occurrence of schizophrenia in relatives of creative persons was related to genetic "heritage". Supposedly, genes that are associated with schizophrenia can manifest

in some people in a form of special abilities and adaptation skills resulting in benefits, while in others they can lead to the disease.

American psychologist Joy Paul Guilford demarcated such intellectual markers like verbal fluency, flexibility of thinking, an ability to redefine ideas, and originality, which was later called diversity of thinking. In the summary of his research he concluded that creativity is a consequence of previous life events. He also examined the combination of creativity with cyclothymia, dysthymia, and disposition to irritation. These can create creative energy, but also contribute to poorer social relationships and possible to depression. The results indicate a combination of creative tendencies and bipolar disorders, as well as related disorders, in the family of the examined person.

H. Eysenck, an eminent psychologist, proposed a theory concerning the relationship of psychoticism, creativity and schizophreniform disorders. He believed that psychoticism is conditioned by the reduction of cognitive inhibition, which is a frequent feature of creative individuals and schizophrenic disorders. Creative people see things that remain invisible to others, have an access to a wide range of stimuli in the early stages of processual thinking and thus a greater chance of thinking originality.

Swedish researchers from the Institute in Karolinska found that the strongest relationship exists between writing and schizophrenia. Moreover, writers suffer bipolar disorder, depression, anxiety more often than other artists. They are more likely to abuse alcohol and take drugs and are about 50% more likely to commit suicide than others. Examples of such people are often discussed in literature. Writers who suffer from mental illness include Ernest Hemingway, Sylvia Plath, Virginia Woolf and Arnhold Lauveng.

Szabolcs Kery from the Hungarian Semmelweis University asked the participants a series of questions exploring thus their creativity. Then he selected the persons with the most original way of thinking and proceeded to genetic testing. In many participants of the study, the gene encoding neuregulin-1 (a protein involved inter alia in the process of neuronal development and formation of connections between them) contained a characteristic promoter variant (sequence accompanying DNA fragment encoding the protein, responsible among other for the regulation of the entire gene activity and the intensity of the synthesis of protein encoded by it). The same change was also frequently noted in people suffering from some mental illness such as bipolar disorder or schizophrenia.

Today, there are many psychometric tools that examine the phenomenon of creativity in patients with bipolar disorder. For example, R. Richards measured daily activity using the Lifetime Creativity Scale (LCS) (Scale of Creativity in Life) which evaluates the creative achievements on the basis of professional and non-professional activity.

The scientists from Stanford University evaluated the phenomenon of creativity in bipolar disorder based on the Barron - Welsh Art Scale (BWAS). The results of the research indicate that the more distant was the time of disease occurrence in family history, the higher creativity decrease was observed. This study also indicates that children with bipolar disorder, who concurrently came from families with the disease in the family history, were more creative on the BWAS scale than their healthy peers.

Other studies have also used the NEO PI-R Personality Inventory, TCI Inventory of temperament and character, and the Temperament Evaluation of the Memphis Pisa Paris and San Diego Auto - TEMPS-A questionnaire.

It was revealed in the Kings Schizotypy Questionnaire that psychotic tendencies, as well as higher creativity tendency are correlated with cognitive latent inhibition mechanism (LI). Highly creative individuals obtained significantly lower scores compared to little creative persons. The results indicate that there is a neurobiological similarity between very creative people and people with predispositions to psychotic disorders. The researchers believe that high IQ can help to transform weakness of latent inhibition mechanism into creative achievements.

TATTOOS ON PSYCHIATRISTS AND PSYCHOTHERAPISTS

Katarzyna Szaulińska

Institute of Psychiatry and Neurology, III Psychiatry Clinic

Warsaw, Poland

e-mail: szaulinska@gmail.com

Tattoos used to be commonly associated with personality disorders and antisocial behavior. Still, many psychiatrists and psychotherapist have tattoos themselves.

Problem statement: It was considered whether tattooed psychiatrists and psychotherapists would be considered mentally disturbed and whether they should show tattoos on public.

Approach: A literature review was undertaken to investigate the expectations towards the outlook of medical practitioners, the past and present stereotypes and associations between tattoos and personality traits.

A brief questionnaire was completed by four psychiatrists and three psychotherapists with tattoos. The questions concerned their motivation for making a tattoo, the reaction of the work community, the decision moment (after or before becoming a mental health professional), feelings of shame about having a tattoo, and experience of showing a tattoo to a patient by accident or on purpose.

Results: Along with cultural changes, the psychological traits associated with owning a tattoo changed, but the stereotype didn't.

The motivations for getting tattoos in the questioned group were not different from the most common: celebrating an important moment, expressing personality and aesthetic reasons. All of the respondents decided to have a tattoo after deciding to become therapists. No single respondent has shown a tattoo to a patient deliberately.

Conclusions: A tattoo is no longer a sign of pathology, so tattooed psychiatrists and psychotherapists should not be considered mentally disturbed.

However, the respondents draw a line between their private life and work area and don't show tattoos at workplace. It is consistent with the expected outlook of medical practitioners.

THROWING A DICE: DIFFERENT PERSPECTIVES ON MENTAL ILLNESS

Katarzyna Szaulińska

Institute of Psychiatry and Neurology, III Psychiatry Clinic

Warsaw, Poland

e-mail: szaulinska@gmail.com

Views on mental illness could be pictured as different sides of a dice. Not only are they numerous but they seem to have different value, from what can be noticed in day-to-day practice. And the more time you spend throwing the dice, the more faces you see.

We have the perspective of a doctor: wise and filled with hope, but dealing with drug side effects, lack of compliance and the expectations included in the position of "the healer". We have the perspective of the nurse, perhaps irritated with the doctor's lack of action towards patient's agitation, staying 24 hours a day inside the ward, the best observer of patient's behavior. We have the perspective of the family, carrying the burden of watching their loved one change, their difficult behavior, loss of security, and often feeling tired and hopeless. We have the perspective of friends, of the psychotherapist, of other patients, of social workers, teachers, employers, philosophers... The perspective of EBM and the perspective of the individual case.

In the end, we have the perspective of the patient-lost not only in the symptoms of disease, but also in all the perspective of the others around him. Will pharmacotherapy change my personality? Aren't they all against me if they want me to take medicine? Should I take medicine if it makes it impossible to have sex with my partner? If it makes me so tired that I can't work?

So who is right? Who on the dice is "six" and who is "one"? The patient, with his mind changed by illness? The doctor, locked in his office? The nurse, just wanting to have some peace? The family, wanting to have the close one "fixed" in the hospital? The employer, wanting to get rid of "the weirdo"? The psychotherapist, who doesn't know anything about medication? We too can get lost in it all, like some patients get lost hearing many different voices.

One solution is to take the dots off the dice and stop thinking of someone's perspective as more important than another's. We should talk more, with more respect, empathizing more with all the sides of the "conflict" called mental illness. Expecting more from ourselves and more from others in an atmosphere where everyone feels important. Working in mental health is team work and we should never forget that we have a common enemy: the illness. Only then fighting the mental illness stops being a question of luck.

HYPERREALITY - A REMEDY OR A POISON?

Roland Zarzycki, MD, PhD (mathematics), PhD student (philosophy)

University of Wrocław

Wrocław, Poland

e-mail: zarzycki.roland@gmail.com

At the ground of twentieth century philosophy it has been observed that our intelligence is bewitched by means of language and so is our human condition, bewitched by means of symbolic sphere. The process, in which socially and practically justified meanings are being torn off the real, leads us through the imaginary and terminates in domination of the hyperreal. As pointed out by Žižek this distraction always involves mechanisms of symbolic and/or structural violence embodied in the form of ideology, which manifests in an individual's world as neurotic fantasy. Whenever it helps to cover the discrepancies between the imaginary and the real/hyperreal, fantasy might be perceived as a buffer preventing mental illnesses. We will show how contemporary metamorphoses of symbolic spheres lead to a detrimental accumulation of hypermeanings and development of attitudes of disinterest and alienation significantly driven by interpassivity.

SADDER BUT SMARTER

Agnieszka Zawadzka, PhD student,

Warsaw School of Social Sciences and Humanities, Wrocław

Institute of Psychiatry and Neurology, Warsaw

Kobyłka, Poland

e-mail: azawadzka.pl@gmail.com

Adequate self perception and effective coping in difficult situations.

Adequate self perception (Metacognitive Self) is demonstrated by Distance from Self and self-awareness. Distance from Self is itself connected with better regulation of emotions (Obuchowski, 2000). Awareness of the emotional state as a part of self-knowledge is a necessary condition to better control mood regulation (Larsen, 2000). It is hypothesized that there is a positive correlation between a strong Metacognitive-self and effective strategies of emotional regulation (i.e. acceptance, concentration on something positive, positive reevaluation and perspective taking). It is

also presumed that there is negative correlation with non-adaptive strategies (rumination, self-accusations, accusations of others, catastrophic thinking). This research did not confirm that hypothesis. The correlation of self-perception and rumination can be explained by our results which suggest that increased situational awareness in some circumstances can be viewed as harmful as it can cause lengthening and intensification of emotions experienced by the person (Larsen, 2000; Lischetzke & Eid, 2006; Parkinson, 1996). According to this research, people with wider self-knowledge can show a tendency to non-adaptive strategies of emotional regulation (rumination) and in difficult circumstances they can retain those emotions for longer time period (i.e. they remain sad for a longer time).

Ayduk & Kross (2010) suggest that when a person experiences hardship, Self Distance is a factor that enables them to be reflective without the risk of rumination. The results of above research don't confirm that assumption. Even though the Metacognitive-self construct has Self-Distance as one of its characteristics, it was expressed concurrently with rumination in our study. Our findings indicate that people who perceive their actions adequately, in difficult situations, use a non-adaptive strategy of emotions regulation.



Young
Psychiatrists
Network

ORGANISING COMMITTEE

Dorota Frydecka (MD, PhD, MSc Eng, Wrocław Medical University, Wrocław, Poland, dfrydecka@gmail.com)

Dzmitry Krupchanka (MD, PhD student, Belarus, Minsk, dmitry.krupchenko@gmail.com)

Michał Klapcinski (PhD student, Wrocław Medical University, Wrocław, Poland, michal.klapcinski@gmail.com)

Nina Kruk (MD, assistant of the department of medical psychology and psychotherapy, Grodno State Medical University, Grodno, Belarus, dlaninki@gmail.com)

Lejla Cakovic (MD, MScandidate, Malmö, Sweden, lelacak@gmail.com)

Jerker Hanson (Assoc. Professor, Psychiatrist, Stockholm, Sweden, jerker.hanson@telia.com)

Jonas Mikaliunas (MD, Vilnius, Lithuania, jonas.mikaliunas@gmail.com)

Laurynas Bukelskis (MD, Vilnius University Faculty of Medicine Clinic of Psychiatry, Vilnius, Lithuania, bukelskis@gmail.com)

Anna Jelen (PhD student, Wrocław Medical University, Wrocław, Poland, Annajelen73@hotmail.com)

Olga Paravaya (MD, PhD student, Belarussian Medical Academy of Postgraduate Education, Belarus, Minsk, olgaparavaya@gmail.com)

LOCAL ORGANISING COMMITTEE

Dorota Frydecka (MD, PhD, MSc Eng, Wrocław Medical University, Wrocław, Poland)

Michał Klapcinski (PhD student, Wrocław Medical University, Wrocław, Poland)

Anna Królicka (PhD student, Wrocław Medical University, Wrocław, Poland)

Agnieszka Drozd (PhD student, Wrocław Medical University, Wrocław, Poland)

Tomasz Gondek (PhD student, Wrocław Medical University, Wrocław, Poland)

Irena Wojciechowska (PhD student, Wrocław Medical University, Wrocław, Poland)

Maja Krefft (PhD student, Wrocław Medical University, Wrocław, Poland)

Ewa Kłosińska (PhD student, Wrocław Medical University, Wrocław, Poland)

Ania Pietrańska (pietrasinska.anna@gmail.com)

Rafał Węgrzyn (rafalwegrzyn93@gmail.com)

Scientific edition

International conference

4th Young Psychiatrists' Network Meeting

“A coin with many sides: different perspectives on mental illness”,

April 3-5 2014, Wrocław, Poland.

International conference: Programme and abstract booklet

Editorial Board

Dzmitry Krupchanka

Nina Kruk

Laurynas Bukelskis

Dorota Frydecka

Jerker Hanson

Greg Lydall

Tomasz M. Gondek

Design editor

D. Krupchanka

Signed for printing 27.03.2014.

Format 60×84 1/16.

Risograf print. Offset paper.

Printed pages 4,8

Edition 100 copies.

Pictures of Wrocław Copyrights:

S. Klimek - ViaNova, ul. Włodkowica 18

Wrocław Medical University