Conference ***2***

Dr Oliver DODT (D)

03/08/2023

Translation: Kathy WEBB-PEPLOE

Experiences in psychiatry and psychotherapy

I am pleased to be invited and to have the opportunity to speak to you today.

Preliminary remarks:
Most of the time I will try to speak freely. To make it easier when reading along in the other languages, I will try to stay faithful to the written text - even if this limits the spontaneity somewhat.

Before I start talking about our topic, I would like to say something about my workplace, as it is unusual - at least in Germany.

0. Where do I work now? Where have I gained my experience?

I currently work in the Würdezentrum (Dignity Centre) in Frankfurt without any contact with patients. I really enjoy working with patients.
The Dignity Centre is a training and research institute. My position is largely donor funded. There is no funding from the regular health system.
The focus of my work is suicide prevention amongst old and sick people. We have developed ideas for pilot projects that we can implement in Frankfurt. If such a project is successfully implemented, it can be taken over into routine care. This has already been done many times with other projects.
Since April, we have had the commitment of the department of the city of Frankfurt that they will take over approximately half of the costs incurred for a pilot project for three years.

I also give courses at the Dignity Centre for medical lay people working in the medical field on how to deal with mental illness. It is called "Mental Health First Aid" in German: www.MHFA-ersthelfer.de or "First Aid for the Soul". The 12-hour course trains lay people to recognise and deal with the symptoms of the most important and common mental illnesses. The programme originated in Australia and has already been introduced in 26 countries:
- in the UK, it was introduced very early as it didn't need to be translated (https://mhfainternational.org/united-kingdom-map-of-mhfas/);
- in France (https://pssmfrance.fr/), there are already a lot of trained first aiders;
- in Switzerland, it is called ensa (https://www.ensa.swiss/de/) and was introduced almost simultaneously with Germany in 2019.

The programme has been scientifically evaluated in each country from the start.

There is already proof of effectiveness for Switzerland : https://promentesana.ch/ueber-uns/aktuelles/news/effektivitaet-von-ensa-kursen-nun-auch-in-der-schweiz-wissenschaftlich-nachgewiesen.

I recommend the training for anyone who is interested; relatives of people with mental illness, marketing managers, human resource managers and group leaders, whether of choirs, sports clubs or church groups. Many employers send their employees on the courses in order to be seen to be providing health education for their teams. Obviously, the courses pay their way as company occupational health promotion.

Another field of activity is talking to politicians and decision-makers. For example, we invited almost all of Frankfurt's members of parliament to talk to us. Six of the seven gave us at least one hour of their time to talk.
All were very grateful for the information derived from the practice of palliative medicine and psychiatry on the topic of suicide prevention and assisted suicide. A law relating to this has been under discussion in the German Bundestag since 2021 and for even longer in the medical world and in society. I will come back to this later.

In my lecture, I will now describe the situations that I experienced mainly in the psychiatric hospital (2002-2018) and partly in the psychiatric institutional outpatient clinic (2019-2022). The latter is a facility for mentally ill people who are too ill for the "normal" psychiatrist in private practice. They are dependent on multi-professional care with additional psychosocial counselling, group meetings, or they need home visits, mostly because they live in old people's homes.

So much for my background and current professional situation.

When I heard the conference theme from the Équipe: "Challenge for medicine - can we reconcile the expectations of our patients with what we can offer?", a big "no" stirred in me. I mainly thought of the situations in which we could not or did not want to meet the patients' expectations. I would like to report on this today and in this way give an insight into the challenges of psychiatry and of psychotherapy.

In what follows, I am talking about a minority of difficult and problematical situations.
Therefore, I would like to clearly emphasise here that for the majority of treatments, the many expectations of the patients, partly also of their relatives, can be fulfilled with the treatments available at the clinic or the existing health care system. Unfortunately, this is becoming more difficult with the increasing number of patients. But on the whole, I am under the impression that this is possible.
In the two most common illnesses if you count treatment days and admissions, i.e. depression or alcohol dependence, the changes were very clear; the measurements (laboratory values, values of the self-assessment and external assessment scales) and the external transformation with changed body language, activities, clothing, well-groomed appearance, etc., as well as the internal changes: improved mood and drive, new hope and plans for the future, ...

Particularly in the case of depressed patients, their expectations were exceeded: due to the illness, they lacked hope. With treatment, they found a state of contentment, and after the subsequent outpatient treatment, they are usually not only "fit for work" again but achieve a

"recovery" or "recuperation". This means that people live subjectively satisfied and healthy lives in their everyday relationships: i.e. social environment, workplace, relationship with their partner, ...

Unfortunately, for many people their social environment is not as positive and stable as patients and therapists would like. Also, the "treatment" does not work as quickly as patients and relatives expect. More time and patience are needed.

My wish for you and for myself is that you keep in mind this positive image of psychiatry with possibilities full of hope and that you can pass it on to your patients.

Please also keep it in mind when I now talk about three not so frequent but challenging situations in which we were unable to fulfil the expectations of our patients.

1. "I am a free person" - "I don't want these medicines".

Treatment against the patient's will: Admission against their will, forced medication, closed wards.

Let's look again at the majority of "treatments":
- approx. 90% of patients are admitted voluntarily for treatment or it proves possible for them to undergo treatment with only some restrictions.

Here, guideline-compliant treatment takes place in agreement with the patient. This is the "main task". Depending on the patient's personality, competence, experience, empathy and their own religious beliefs, the patient is seen holistically:
- as psychotherapists (psychiatrists and psychologists), special therapists (occupational therapy, sports therapy, dance therapy, animal therapy) we take care of mental and psychiatric illnesses and problems.
- Together with social workers we try to solve problems with insurance coverage, benefit payments, with the employer, etc.
- In the best-case scenario, there is good communication with the nursing staff, which is helpful for the treatment.
- The relatives are not only informed about changes while respecting confidentiality but are actively involved in the treatment according to the interests and wishes of the patient.
- Occasionally, in the intense and trusting environment, the patient not only asks his spiritual questions, but listens attentively, and appreciatively joins in seeking answers.

So much for my - possibly rose-tinted - look back at some of the great memories of the acute ward.
As the years have gone on, the lack of time, nursing staff, sufficient doctors who are fluent in German, as well as the increasing pressure of patients to be admitted urgently and economic considerations have increased.

The challenge lies with the 5-10% who do not want to/cannot fit into the "scheme" - due to illness / personality / their past / ...

To name a few examples :

- ✓ A young man with recurrent drug-induced psychosis. He hears the voices of thousands of suffering children and thinks he has been chosen by a cosmic world government to save them. Due to his delusion, he is uncooperative towards his mother and later also aggressive, first against things and later also against his environment. He is brought to the clinic by the police.

- ✓ The patient with psychosis has stopped taking her medication, whereupon she develops delusions again: She says that there are surveillance devices in the electrical fuse box. Therefore, she tries to discover and remove listening devices in the electrical installation of the power lines with a screwdriver and her bare fingers. Her husband brings her to the clinic with the help of a pretext. Due to the considerable danger to herself, an "application for accommodation in the clinic even against her will" is made and in due course this is also approved.
  The patient then suspects that her husband has a mistress and that is why he is placing her in psychiatric care.

- ✓ The woman with dementia who does not feel at home in the old people's home and instead repeatedly runs "home" to care for her long-dead parents. After the court-appointed guardian agrees, the facility calls an ambulance to bring her to us.

- ✓ The alcoholic man, who hit his partner while drunk, is brought to us by the police. After initially appearing irritable, uncooperative and in a fluctuating mood, he lies down in bed and "sleeps it off".

It is a mental challenge to keep explaining in a friendly way to the patient who is refusing something, that it is necessary for him to stay in the clinic, even against his will. It takes time to create the conditions with the courts and the legal guardians that he may be accommodated in the clinic against his will. In some cases, requirement for increased documentation is also necessary.
In the semi-open wards, the team had extra work due to patients who were non-compliant e.g., the four mentioned above. The exit and entrance doors, which are otherwise open, must remain closed due to the risk of running away, i.e. care must be taken with every visitor to ensure that no one escapes.

How could these patients in the examples above progress?

- ✓ The young man with the drug-induced psychosis has had many more stays. It always takes a long time for his delusional thoughts to recede under appropriate meditation. It is not possible to motivate him or enable him to lead a drug-free life. Placement in a sheltered facility seems to be the only way out to end his constant relapses and the ensuing conflicts with his mother. Unfortunately, the number of places in long-term institutions has been reduced and the legal requirements have been tightened. I.e. his aggressiveness towards things and persons has so far not been sufficient to achieve a corresponding longer-term placement, which is not designed for treatment but for custody.

- ✓ The woman with the psychosis finds it very difficult to engage with taking medication during this as well as her subsequent stays. Through various initiatives by her husband, nursing staff and therapists, a reward system (concessions on the days she takes her medication) can be used to make the delusions disappear.
  Unfortunately, after a few months, she stopped taking her medication again and further inpatient stays occurred. She also stopped the depot medication after a while. We were not (no longer) authorised to administer a depot medication against the patient's will. The legal hurdles have become much higher.

- ✓ In the case of the demented woman who has repeatedly run away, a drug for dementia is used, this reduces her inner restlessness somewhat. She is discharged after a few days with the recommendation of a clearly structured daily routine with walks, plenty of daylight and occupational therapy if necessary.

- ✓ The man who beat his wife while drunk cannot remember the incident the next morning. He has no memory of the previous evening. He remembers drinking two bottles of beer. There is obviously a pathological intoxication, i.e. after moderate alcohol consumption, the person's personality changes massively and he has a memory lapse.
  As he does not want to lose his job, he insists on immediate discharge. There are no reasons to keep him in. An addiction counselling centre is strongly recommended to him. The wife, who was not our patient, is informed about this and about the discharge by telephone. (This is already borderline in terms of confidentiality). She is also informed that she should seek counselling for her protection. She can also file a complaint for domestic violence.

How do you manage to endure this constant rejection?

1. It helped me to not give up hope that the patient would eventually agree to treatment.
2. I had the hope that the effect of the antipsychotic medication, attentive care and trust-building measures would make it possible to build up a relationship. In this way, many an understanding or compromise could be reached.
3. Of course it helps to respond to the patient's wishes (telephone calls, visits by people the patient trusted, going out in company, occupational, sports or animal therapy, or other experiences that were pleasant for the patients).
4. it is worthwhile to look out for the "nice parts" of the ill person: although many parts of the personality are clearly changed, one can discover a likeable side and a humanity even in severely psychotically ill people.

That was the first group of patients whose expectations I could not fulfil.
Now the second group :

2. "I would like to be able to forget this terrible event". "I don't want to have this in my head anymore".

It is not possible to fulfil the expectations of the patient.
Here I am thinking of different groups of patients:

- ➢ Psychotherapy brought to light certain patterns of evaluation (e.g. increased performance expectations). These are disturbing in everyday life because they make change difficult. It is hard for the patients to change these long-standing internalised beliefs - mostly held since childhood.

- ➢ Patients with a history of trauma want all memories of the terrible past to be erased.
- ➢ Obsessive-compulsive patients want to get rid of their tormenting symptoms. I have only rarely seen serious forms of the disease. Many are probably undiagnosed with no access to self-help groups and going forwards have poor beliefs and/or problems with their environment.

For patients such as these, change as quick and easy as they would like is not possible. The journey goes through many years of treatment, which requires a lot of perseverance and commitment from therapists and clients.
For treatment, it is necessary to be able to create an atmosphere of trust and hope, where the client can open up and have the expectation that the effort will be worthwhile.

- Trauma therapy requires perseverance and relearning. It is necessary to give the patient hope that the treatment will be worthwhile.
- For people who have lived with difficult habits and thought patterns in their everyday life for decades, it is very difficult to change them. Sometimes this is so difficult that they drop out of psychotherapy because it seems too tedious or even hopeless.

Some would much rather take the simpler path of swallowing a pill to make their behaviour change. Many of us will know for ourselves how difficult it is to change habits or patterns of thinking. How much more difficult it is for people whose thought patterns have made them manifestly ill.

It is worthwhile to talk about the patient's expectations, to explain what is possible and what is not. And thus, to set achievable therapy goals.

3. My (professional, moral, personal, ...) obstacles to fulfilling the patient's wish : "I need help in my life" - "I need help to die".

There were a few examples of this in my everyday professional life:

- The single elderly lady had tried to take her own life. Neighbours noticed that the shutters were not raised and called the emergency services. They had the front door opened because of the threat of imminent danger. She was found drowsy with empty packs of tablets and a suicide note. After examination and physical stabilisation in intensive care, she came to us: the reason she gave for her desperate act was the defective heating - she has no money to buy a new heating system: How can we help her? Should she sell her house and rent instead, or move straight into a nursing home? She won't want to and the proceeds from the sale of her house won't last long. Since there were no children, potential heirs or persons of trust, socio-medical counselling was hard for the old woman: she seemed self-centred, ashamed of what she had done and was overwhelmed by the daily routine on an acute psychiatric ward. And we couldn't keep her in the clinic for long at health insurance costs if we couldn't make a definite diagnosis: (old-age) poverty is not an ICD-10 diagnosis.
  Unfortunately, I cannot say for sure what happened to her next. Presumably she was given a court-appointed guardian (who can get an overview of finances, the various options and constraints and then make further decisions - preferably in the patient's best interests). She was probably transferred to short-term care (a place in an old people's home which is limited to 6 weeks). An assessment could occur during this time,

whether a permanent placement is necessary, or it is possible for her to live and be cared for elsewhere).

- One man had managed to get an urgent emergency appointment at the psychiatric outpatient clinic -the staff check the urgency and medical indication carefully – the reason for his emergency appointment: that he did not know which woman he should choose: "Do I stay with my wife, or do I move in with my girlfriend?". I told him clearly but firmly that this was not a psychiatric illness and that my clinic was not the right place for him. Even as a psychotherapist, I did not want to, and could not, take the decision for him. (It would be professionally wrong to take the decision away from him because he would not take responsibility for it himself, but wanted the decision taken by someone else than himself.) He had to find the criteria himself according to which he could make the decision. When he was visibly overwhelmed by this, we briefly collated the criteria together so that he could use them to decide. He did not come back.

- The married woman who expected me to bring back her partner who had left her. There I also did not want to and was unable to do what she wanted.
  If patients were prepared to do so, I tried to work with them in the light of these expectations, to examine their share in the failure of the relationship: the absent partner is not 100 % to blame for the failure of the relationship. I told the partner sitting with me that he/she bears at least 1% of the responsibility. With that it was possible to start a conversation on the subject. My impression is that few could or wanted to engage in reflection in this situation - maybe they just needed more time to change their expectations: she still wanted her partner back.

A fundamental and at the same time challenging expectation of patients is the wish for assisted suicide or killing on demand.

Killing on demand means: the doctor (or other person) administers a lethal dose of a substance (as a gas or intravenously). This is not permitted in Germany or in most other countries. Holland is an exception, but only if specific conditions are met.

The big topic among medical ethicists, doctors, theologians, and related disciplines is assisted suicide. The doctor provides the drug to the suicidal person, who must administer it to himself.

Here, until 2020, I could say that I could get myself into trouble by doing it as a doctor and clearly refuse it.
Since February 2020, things have been different due to a ruling by the Federal Constitutional Court: I was allowed to provide someone with medication to commit suicide. This is currently possible in Germany regardless of pre-existing conditions, certificates or the like. Age also plays a minor role; depending on the individual case, minors can also avail themselves of assisted suicide. The only thing a doctor has to check is that the patient is taking the decision freely, which means that no influence from outside (e.g. poverty, relatives) or from inside (e.g. severe mental illness) is detectable.

What is the politico-legal situation regarding assisted suicide in Germany?
In February 2020, the Federal Constitutional Court deleted §217 (prohibition of commercial assisted suicide), which had been in force until then, without replacing it. Since then, it has

been possible (again) for organisations promoting assisted suicide to offer their services in Germany and to provide people and those wanting to commit suicide with the appropriate means or methods, which they must then use independently.

Since then, anyone may offer assisted suicide: "professionals", associations, individuals, relatives. There is currently (as of June 2023) no documentation, obligation to register or minimum requirements for the provider. The market is currently completely unregulated: Germany has the most liberal regulation for assisted suicide. Last year, at the Medicine de la Personne conference, I spoke to a psychiatrist from the Netherlands. She was completely appalled that there is such lax regulation in Germany.

Even supporters of a liberal regulation on assisted suicide were not comfortable with the completely unregulated "market of providers" for assisted suicide. Therefore, three cross-party bills have been discussed in the Bundestag and in the wider society for about 2 years. In June, the two permissive regulations were merged into one proposal.

In this very fundamental decision of conscience, it is customary that the parliamentary party whip is removed in the Bundestag, i.e. the individual representatives of the people are not bound by the guidelines of their parties or parliamentary groups. Most recently, this happened in the case of issues relating to medical ethics (it has happened once in the last 3 years in 2021 in a vote on compulsory vaccination).
The vote is to take place on 7.7.2023.

The professional association of psychiatrists (dgppn.de) stated emphatically that assisted suicide is not a job for the doctor, but it could be carried out by the doctor in individual cases. They demand two examinations by a psychiatrist (to exclude a serious psychiatric illness that restricts their capacity to make an independent decision) and a counselling appointment at a counselling centre to be set up to address the patient's problem. The correct prerequisites should be checked by a local court. Only then may an appropriate poison or method be provided without penalty.

At present, there is great uncertainty among doctors, nurses, and institutions :

- May I offer assisted suicide? - Yes, provided the person has free will. This is difficult to determine. After the law is passed, there will be minor or major restrictions.
- Do I have to provide assisted suicide at the request of an employer or another person? - No. No one can be forced to offer or perform assisted suicide.
- Can old people's homes prohibit the offer of assisted suicide? Probably only partially:
  * Via labour law: no suicide assistance during working hours.
  * House rules: no advertising in the facility, no access for assisted suicide organisations. Is it reasonable to push it underground?
- What is a sensible attitude: openly addressing suicidal impulses, weariness and being tired of living / appreciation for honestly expressed life-denying thoughts / attempt to relieve the burden by talking and if possible, the underlying problems: depression; pain; sleep disturbance; loneliness; arguments; financial worries; fear of illness, dying or loss of autonomy, and others....

Assisted suicide gives us a lot to think about, where one's own attitude lies between the two ends of the spectrum ("Christian protectors of life" and "compassionate assisted suicide"), and so on.

Among the dangers of a permissive regulation on assisted suicide, "toxic compassion" should be mentioned: the setting where the suffering person finds themselves where relatives or nursing staff can no longer bear the suffering themselves and therefore offer assisted suicide very generously.
You are welcome to discuss these issues in the small groups.

Finally, one last aspect about patients' expectations:
Some of the seriously ill psychiatric patients have no expectations or/and are not aware of the illness: they do not go to the doctor or to a counselling centre.
What should we be offering (as a society, in health care, marketing managers in associations/ church/neighbourhood/family, ...) so that more people get (earlier) treatment (and cure)?

Even though MHFA courses (Mental Health - First Aid) make a lot of sense, In my opinion, it is not enough to disseminate them and to have more first aiders. What else can we do?

There are quite a number of people in Germany who have no expectations in the area of suicide prevention:

- The health insurance companies must pay a certain amount into a prevention fund for every insured person every year. Millions of euros are lying here and are hardly ever drawn down. Suicide prevention is unfortunately not part of the funding guidelines. Obviously, little or nothing is expected here.
- The health system does reward preventive services, especially courses on nicotine withdrawal, getting people back to school and relaxation. There are only small financial incentives for people who are insured to complete their vaccinations, participate in cancer screening, become members of a sports club; slightly better ones for achieving BMI targets and nicotine abstinence. But these seem to me to be so small and inconvenient that in my opinion hardly anyone changes their behaviour because of them.
  Even more so, I am not aware of any incentives for health professionals that improve sustainable practices that promote health, or improve health outcomes.
- The state has hardly any activities on the topic of suicide prevention. In the coalition agreement of the current federal government, "suicide prevention" is mentioned for the first time.
- In Frankfurt am Main - the "Mecca of suicide prevention in Germany" - the topic is also in the coalition agreement of the city council. Therefore, there are 1.5 jobs in this area. That is probably more than other cities have, but is it enough to meet expectations?

What do we expect from those who prevent assisted and "lone" suicide in cases of mental illness? Some feel that the tendency is to eliminate sufferers rather than address suffering.

A representative survey by INFAS showed only low levels of support for assisted suicide among healthy people.
For terminally ill people, assisted suicide (at 80.5%) is supported significantly more often than for "only" seriously but not terminally ill people (at 37.6%). For people in life crises (without illness), support is significantly lower, and increases with the age of the person: from 2.7 % for younger people to 4.1 % for people in middle age to 10.3 % for older people.

Many churches and Christian groups are concerned that assisted suicide is becoming increasingly normal in our society.

What would Paul Tournier have said about the current challenges in psychiatry and society? At that time, he had added the spiritual dimension to the psychosomatic way of thinking. This concerned mainly the individual patient, perhaps also his immediate environment.
My thought - or expectation - is that today he would again expand his view beyond the individual patient and his environment: to those who are not in the immediate environment of our patients. All of us - whether in health care, the church, or individuals - are challenged to look at those who are not facing us. We are also challenged to look at those who have turned away, at those who no longer have expectations.

Perhaps some people in the wider community feel like the paralytic at the Pool of Bethesda (John, chapter 5): he was chronically ill for 38 years. This significantly limited his physical, social, cultural, and probably spiritual activities. For various reasons, his social network was probably reduced to fellow sufferers. He had no hope left - or to go with the theme of the conference: he had no more expectations.

How many people are there in our prosperous countries who no longer have any expectations? Do we also need people here who follow Jesus' example: He went to the person who had no lobbying association, no self-help group, or no legal proxies, and brought him more than that person could have expected for himself.

My wish/my hope is that we can :

* all live relationally, take action against loneliness;
* as a society promote worthwhile initiatives: telephone counselling, counselling centres, guidelines for education, research;
* as doctors, healthcare professionals (on behalf of specialised therapists);
* as churches and Christians: a culture of appreciation, a love of neighbourhood, e.g. "Extra Mile", which also offers companionship if the path is difficult.

I would of course be interested in the experiences from your countries. Feel free to ask me about this later.

How do you deal with those who no longer have any expectations? Are they part of your system (society, healthcare system, churches, associations, neighbourhood) and your thinking?