Modum Bad – Unraveling the X-Factor in Psychiatry's Impact

Psychiatry, with its approximately 150-year history, offers a fascinating glimpse into the latest phase of Western civilization. Despite varying perspectives, psychiatry is an integral part of the European Enlightenment project, driven by ideals of growth, knowledge, reason, equality, improved health, and democracy. While psychiatry, like any science, can be a tool for power, it also presents unique opportunities for liberation under certain conditions.

Exploring the conditions for making mental health liberation accessible to all necessitates understanding the interplay between Enlightenment ideals and practical implementation. Unlike many Western countries where public healthcare often falls short, Norway and other Nordic countries maintain a strong commitment to providing mental health services to the entire population. Mental health is considered a crucial democratic symbol.

At Modum Bad, dignity serves as a paramount symbol. It aligns with meaningful ideals connecting mental states and social relations. Patients associate dignity with equality in social relationships, emphasizing the importance of being genuine participants. This notion hinges on freedom to choose engagement, meaningful critique, genuine follow-up by therapists, and the institution's true commitment. Dignity is not just a concept but a lived experience tied to relationships with fellow patients, interdisciplinary teams, sports, clergy, and evening-night staff.

Nordic equality, or "makenhet," involves actively creating equality in social interactions, acknowledging differences without imposing hierarchy. This practice stands out, not just in small communities but also in formal institutions. The Nordic emphasis on conformity within common norms allows for individual freedom, creating a unique understanding of personal independence protected by shared norms.

Examining Modum Bad, despite its bureaucratic nature and challenges in contemporary healthcare policies, reveals its ability to foster healing, security, dignity, and meaning. Key factors include dismantling traditional psychiatric privileges, promoting interdisciplinary autonomy, prioritizing research-based therapy, and maintaining a delicate balance between hospital and cultural functions. This unique institutional model reflects Nordic characteristics, encouraging active cultivation of conditions for patient well-being through shared norms and internal tensions.

In conclusion, Modum Bad, rooted in Nordic principles, exemplifies the potential for mental health institutions to balance strong communal norms with internal tensions, fostering not only individual well-being but also institutional learning and adaptation.

In various forms, this emerges in some of the psychotherapeutic main themes at Modum Bad and other psychological/psychiatric arenas, such as shame, boundaries, and attachment. We have had the opportunity to observe these themes as they unfold, especially in therapeutic group processes. Equality in interaction is a social and cultural common good of a special kind. As I tried to explain earlier, equality in the Western world is much more of an ideal than a social reality. There is no doubt that this is related to mental health. One commonality among the patients we have encountered at Modum Bad is their emphasis on the close and intimate connection between healing processes and equitable relationships. Consider the concept of respect, which is an integral part of this. We are all familiar with social situations where it is possible to be respected despite being deemed less valuable, such as when dealing with generous people of high status and prestige. But equality is different.

The difference can be illustrated by examining one of the most central symbols of mental illness we have encountered at Modum Bad: shame. In hierarchical situations and societies, shame is particularly linked to the loss of honor. However, the version of shame we have encountered among patients here is potentially a much more fundamental identity-undermining factor for the individual. The strong version of shame is, as we have observed it, "I am wrong." A third version, which can probably be described as somewhat milder, is what we loosely call "Nordic shame." It tends to be created in social contexts where one is responsible for adhering to strong norms that few speak directly and openly about. This phenomenon is not a remnant of a more traditional social order but a genuine cultural child of social interaction where equitable relationships are strong. The social shame it risks imposing on us is linked to the weight of conventions we are unsure if we can live up to, and it is rarely or never tied to a clear language or identifiable authority.

One of the costs of equitable interaction of the "Nordic" type seems to be that it requires intense and continuous attention because it places such high demands on sincerity and respect for the common good, i.e., the norms and morals we create and continuously maintain to regulate the community and common interests. There is rarely a "recipe" in the form of an etiquette and other clarified interaction rituals. Assuming that everyone can understand the discreet codes almost always presupposes too much, but much of the point seems to be to invite everyone to adopt them.

One of our strongest hopes when we came here was to study how therapeutic group processes actually create common goods of this kind. When we followed a couple of groups in Vita and Angst, and to some extent in the Eating and Family Department, we noticed that participants often created, or tried to create, situations where they could acknowledge each other with reference to a foundation of shared norms they had created themselves. This almost always involved acknowledging some form of performance, a type of work that required discipline and great risk – especially the ability to step out of one's comfort zone to reach a new place with a new existential view.

Recognition, and the testimonies it rested on, often gave such processes the status of authorized reality, and it was unnecessary to worry about convincing others later about the changes that had occurred. In the creation of such circles, there was also an expansion of what the participants agreed on. We can call this the development of common morality or a cultural common good. This morality or common good acquired its own value, and although it was not directly visible, it was often subject to reflection and negotiation, such as when discussions arose about personal boundaries, what individuals were expected to share with others, the level of support members could expect to receive, and so on.

In the best cases, this became a source of identity and pride in what they had created together, in addition to being the foundation for the security that most believed is the basis for everything else. An important premise for this description is that something is unlikely to be possible without an extraordinary ability to make equality a fundamental premise in social interaction.

An important characteristic of such common goods is, as mentioned above, that they are often nameless. If they are given clear names, they quickly lose their value because they can appear as something imposed, as empty ideals or rhetoric, something someone claims special ownership of, or rules that demand obedience. The same property applies to the communicative codes that allow them to be created, shared, and adjusted repeatedly. Therefore, we can call these discreet or implicit codes. Just as Nordic culture seems to contain a particularly large repertoire of discreet codes, Modum Bad is probably exceptionally rich in them. This is despite the therapeutic models being based on a distinct clarity so that patients can actively engage with them. The richness of discreet codes implies, as suggested, potential for strong, equitable reciprocity. At the same time, it comes

with a cost: it requires strong socialization, and people outside the insider community have poor prerequisites for understanding the expectations until they have observed it over time and made many mistakes. In some situations, this is what makes equality-oriented communities appear exclusive; they can set the boundary around the community or part of it and create outsiders wondering why they feel excluded. The strength of discreet codes lies primarily in designating the "content" of community in a way that makes the community credible, meaningful, and safe. Because it is not imposed, it is perceived as the participants' own creation, and because it is actively respected, it creates a kind of acknowledgment for their investment in each other's individual projects. At the same time, it designates a collective morality. In many different situations during our stay, we participated in celebrations and festivities created by the participants in a group. In the Vita group that concluded the stay in the fall of 2014, this revolved around trust, for example. Several participants emphasized that they had been involved in creating a new foundation of trust; the group allowed them to trust others enough to set aside some of the most stressful forms of self-control. They had achieved this because they collectively created conditions for sharing. Similar events occurred in Nora 1 and Nora 2 around the same time, and in the Depression Department.

The sharing we observed in these contexts had some characteristic features. Above all, it followed a principle of balanced reciprocity. This meant that negotiations about how much was given for one's part and received from others always referred to an ideal of balance over time but never involved an explicit discussion about what each individual might owe others. The ideal of equality comes to the fore here because directly stated demands for a certain type of reciprocation to restore balance are understood as an untimely order or a rejection of the idea that relationships are created by balancing reciprocity over time. Furthermore, the sharing was almost always clearly regulated by a desire to show moderation regarding "taking up too much space," as many expressed it. This last point is especially interesting because it suggests that the group cultures, as I describe them here, do not simply reflect common, everyday interaction patterns. The ability to share was developed based on a fundamental discomfort with the idea that one might risk overflowing and thus trampling on others' autonomy. This is another aspect of what we, for simplicity, have referred to as Nordic shame. Respecting others' culturally defined right to freedom from having others' private worlds too close and uninvited is a strong normative guide in many social contexts in the Nordic region, and it is different from a cold shoulder, pathological modesty, or lack of refinement.

"The phenomenon referred to as 'the whole,' experienced by those inside Modum Bad for weeks or months, is multidimensional. It serves as a contrast to other institutional experiences due to Modum Bad's transparency, especially in the use of a characteristic knowledge model. Knowledge is presented in packages open to critical examination, fostering reflective distance. Therapists and patients discuss and view themselves from an external perspective, creating opportunities for reflection.

Modum Bad's departure from authoritative therapy to evidence-based therapy aligns with the cultural reliance on knowledge. Knowledge is used as models for practical actions, often treated as if they are true. Observing practices in Anxiety, Vita, Eating, and Family departments reveals how patients often act on assumptions about social expectations, creating both functional and costly outcomes. Therapy involves creating models to approach desired relationships or states, requiring anticipation of the future.

Therapeutic models, exemplified in group therapy, emphasize risk-taking, reciprocity, and trust-building. Patients navigate social environments, experimenting with 'AS IF' assumptions, creating safe conditions to take necessary risks. The process involves conceptualizing and acting as if the desired outcome is already in progress.

The therapeutic models, although 'constructed,' are rational and research-based, reducing the risk of ideological entanglement. Critical discussions on model credibility occur in the departments, fostering both engagement and reflective distance. Patient interviews indicate the importance of environmental responsiveness and safety, contributing to therapeutic success.

The therapeutic models act as collective journeys, facilitating movement, growth, and renewal. Patients experience three social elements: full membership in a community, an environment encouraging new experiences, and affirmation from trusted individuals about personal renewal. Social realization of these elements is crucial in the therapeutic process, transcending the limitations of individual conversations."