THE NORDIC PSYCHIATRIST

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Leadership

NORDIC PSYCHIATRIC ASSOCIATIONS

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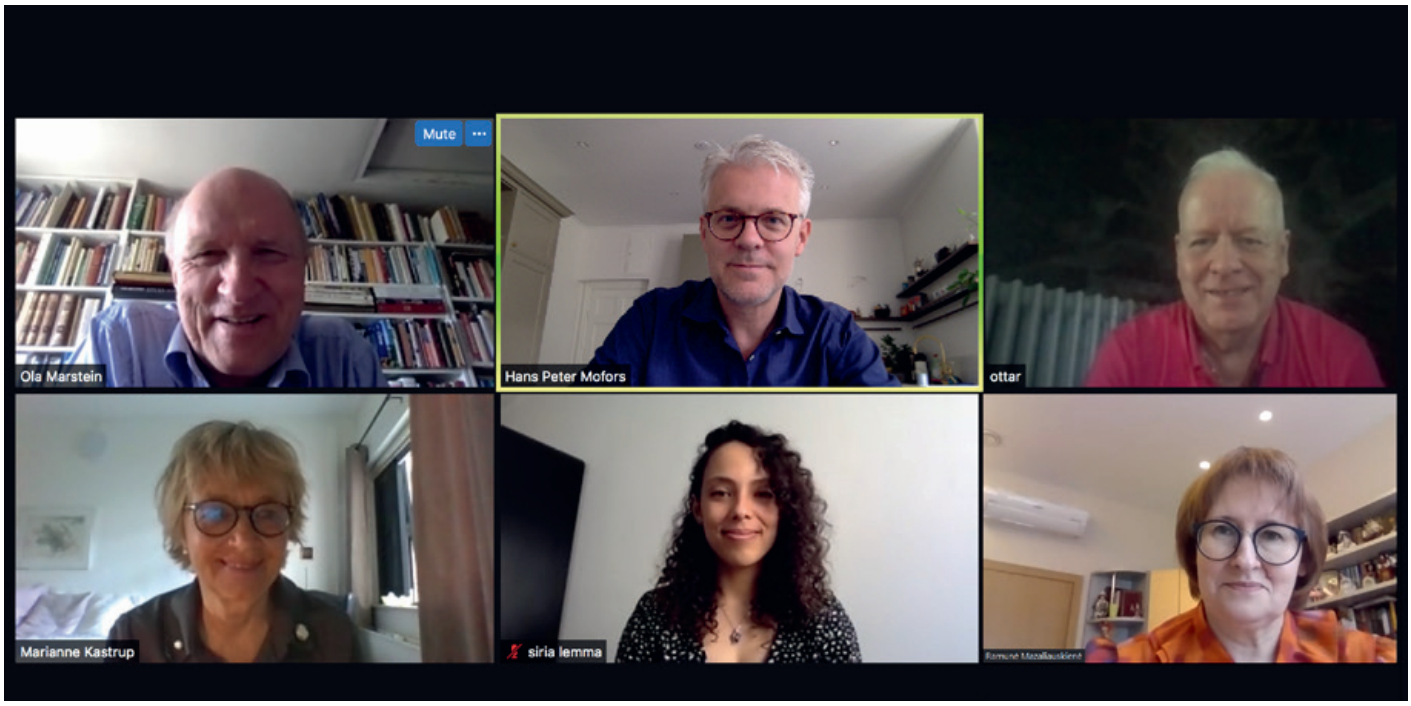

The Editorial Board
Upper row: Ola Marstein, Hans-Peter Mofors Óttar Gudmundsson
Center row: Marianne Kastrup, Siria Lemma, Ramunė Mazaliauskienė,

Dear colleague,

I hope that all is well with you both personally and on the professional front. There are many factors that affect how we perceive our working situation - the work environment, professional development, stress and more philosophical questions like meaningfulness of what we do. In our daily work as psychiatrists we act as leaders, one way or another, be it in patient care or more formally as a chief in a workplace. Even as chief one often has a superior to relate to. In other words, we are all both objects and executors of leadership.

Most of us have both good and bad experiences of leadership. At best, we can feel inspired and appreciated by our chiefs, that again facilitates our work. On the other hand, poor leadership can lead to stress, a bad work environment, and possibly negative effects on one's own health.

In this issue of "The Nordic Psychiatrist" we will focus on different aspects of leadership. What are the characteristics of a good leader? And what are the signs of ineffective leadership? Do individuals in chief's positions possess certain personality traits?

We will also discuss aspects of one's own leadership. Which factors affect our professional choices? Are you the leader in your own life? Also in the clinical situation, how do we help our patients take control and become leaders in their own lives. Maybe sometimes we do not have enough time to stop and wonder about these reflective questions. Yet as we age, we probably begin to spend more time with these themes and other profound questions.

In this issue, we have interviewed several people with a vast experience of leadership in both smaller and bigger organizations. In the following articles, they share their reflections and wisdom with us. As in every issue we touch upon some historical and other aspects of psychiatric medicine. Since this journal is our common voice of psychiatry in Northern Europe, feel free to send in suggestions for future topics. Maybe you would even want to contribute with an article, in which case do get in touch!

I wish you an interesting read and of course good experiences of leadership in the future.

Hans-Peter Mofors,
Chief editor

Introduction

Ramunė Mazaliauskienė

This issue is about leadership. Different kinds and different aspects of it: leadership as a part of management, leadership as an important part in your own life, leadership in medicine, and leadership in psychiatry, ect. Together with the multiple voices of our authors I would like to add a few thoughts about the leadership in the Nordic Psychiatric Associations (NPA). As I think that this association was created to take leadership in the Nordic area, including Scandinavian countries, and Baltic countries.

The idea behind, probably, was similar goals, similar problems, and similar possibilities that could be shared together with certain differences that makes collaboration creative and not boring. Meeting of representatives from each country is an exciting process of shared decision making: what to do, and how to do.

And this was the topic of the board meeting on November 26, 2021, when representatives of member countries met in a zoom meeting to talk about the goals of a new board that started its activities in May, 2021, - just before the Nordic Congress of Psychiatry took place in Finland, in June. It was a meeting where we concluded the results and discussed the lessons from the Nordic Congress, and this time we had to decide how we should proceed as we want to have a great event in 2024 – Nordic Congress of Psychiatry in Riga, Latvia. It is our mutual responsibility – not only Latvians (!) - to make this event happen: great place to meet, have clinical discussions and scientifical excitement, social events, and to do all this in very unpredictable times. It also means that we must tolerate certain uncertainty probably until the very day of the congress, as many things could happen. The Finnish Psychiatric association was the first to meet this challenge this year, they have done a wonderful job.

Ramunė Mazaliauskienė
Chairman of The Nordic Psychiatric Associations

So, to conclude. To me the leadership in the Nordic psychiatric associations is sharing – problems, ideas, and fun, doing – even if there is no certainty that it will work, doing it together and including all associations on equal basis. And, of course, tolerating something that is a strong feature of nowadays – uncertainty. ■

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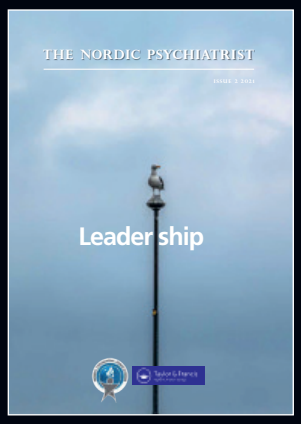

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Bad manager

Óttar Gudmundsson

I have come across many different administrators in my long professional life. Two types come especially to mind when I think about bad administrators. Both of them consist of the characteristics of several administrators that I have served under.

The first one is a passive administrator who possesses fine scientific experience, good education, has written several papers and has worked in many parts of the world. Despite an impressive CV and an outstanding career, this very same administrator seems to be engulfed by a minority complex and insecurity. He stays invisible, locking himself in his office and seeking solitude from his colleagues. The period of locked doors was used to describe him whereas his predecessor emphasized always being visible. This difference in the management style was therefore particularly striking.

This administrator suffered from decision phobia and tried constantly to postpone everything "…until tomorrow". He had no compassion for others and any notion or understanding of what a bad administrator he really was. His immediate subordinates were constantly occupied in protecting him against any kind of stimulus, as he did not want to shoulder any administrative responsibilities. This administrator was literally surrounded by chaos due to the absence of workplace strategies and organization. The middle subordinates had free hands and every decision making was highly coincidental. This in turn led to the workplace being inoperable and was instead run as a cluster of small duchies with small kings ruling without any collaboration whatsoever.

The other administrator was totally the opposition of the aforementioned one. His education was rather poor and his work experience was unilateral. He had become an administrator by coincidence. He was very insecure and worried about his position, namely about someone possibly overriding. This man reigned with terror characterized by him opposing others flourishing or succeeding in his presence. In many ways he was an efficient administrator in favor of the relevant institution, whereas others had to obey him to the fullest or leave the institution. There was never any option allowed for dialogue or an exchange of views as he deemed this to be beneath his dignity.

These two administrators were certainly different in their mannerisms and work. One was passive and invisible while the other was very active and visible. Their respective subordinates never got the impression that they were significant or a necessary part of a complex chain. It may be said that both exercised arrogant management that was characterized by their lack of communication with their subordinates. In both instances the interaction was on the premises of the relevant administrator which the employee were forced to adhere to.

Óttar Gudmundsson, MD
Psychiatrist. Landspitalinn University Hospital, Reykjavik, Iceland

What characterizes a bad administrator?

1. They have no comprehension about their competence or lack thereof.
2. They do not see the negative impact they have when working with others or how this affects the achievements and performance of the undertaking.
3. They blame others when things go badly.
4. They have absolutely no conception of how they appear to others.
5. They have no sympathy with others.
6. Frequently the immediate subordinates' duty is to shield others from the problems at the top.
7. Rule of terror; no one dares to say anything.
8. Sometimes it appears as if the undertaking deems it in its interest to maintain the bad administrator because the performance of the entity may be good even though the personnel feel badly about him. ■

Leadership and Women

Marianne Kastrup

Marianne Kastrup MD., PhD.
Specialist in psychiatry, Copenhagen, Denmark

Present status

In most Western countries women comprise more than half of medical students and medical graduates. But in most parts of the world male preponderance among doctors increases, the higher the position in the academic hierarchy. Yet a vast majority of the medical establishment believes that qualified leaders will reach the top, irrespective of sex.

Leadership

Traditionally, reasons explaining the lack of female leaders include: "the presence of women in medicine is realtively short", "family reasons prevent women from competing" and "women lack the required leadership skills". However, failure to advance is largely due to systematic disadvantages that women face, rather than any of the previously given reasons.
Women who managed to climb up in the hierarchy had to sacrifice more regarding to their private life than men in similar positions. Yet this dedication to their career also adds to their quality of life.

A literature search about the issue offered only few recent hits (2011). Does this reflect that the topic is no longer considered relevant as with higher proportion of female doctors the proportion of female leaders increases and results in an equitable representation of women? In the 1980's Equal Opportunity Committees and committees on women's health emerged. As a co-founder of such committees, I recall how initiatives very often were met with certain ridicule. At an anecdotal level the 100-year anniversary for the first Danish female physician was celebrated with an all-female issue of the journal of the Danish Medical Association. But the male editors were deeply concerned for the scientific quality having women solely responsible for the issue.

Barriers

Women encounter particular barriers on the way up, some related to structural, some to organizational, and others to personal factors. Structurally, impediments may be part of the medical hierarchical system, where men have an opportunity to progress whereas women eventually reach the "glass ceiling" and progress no further.

Organizationally, men seem to negotiate special rewards for their services more easily, and thus end up having higher salary. Also, the current maternity leave politics may serve as a disadvantage to women if used to push women aside.

Personally, female physicians are caught in the complex web of family commitments, emotional caretaking, and stress factors, but also hopes of having influence and academic success. Even in relationships where both partners have a similar education, women are more likely to prioritize family commitment over their career.
This leads us to the following question: do women want to achieve leadership postitions to the same extent as men? Or are they more iclined towards person-centered areas in life while men are more result oriented?

A way forward

According to EU commissioner Viviane Reding there are 4 reasons to break the glass ceiling for female leaders.
First an economic reason. With more women in the workforce, there are more people on the labor market. Secondly, increase in female leadership positions increases the economic capacity of the organization. Thirdly, female quota are introduced in some countries as a possible mean to get more women in leadership positions, and finally the European population is overall in favour of gender equality believing that both sexes possess the same leadership abilities. Modern management views leadership as being a role model and creating an atmosphere of trust and respect and communicating values– all areas where women are strong.

Finally a few clues to ponder: Find a trustworthy mentor who is willing to spend time with you; become part of a team – in an area of your interest – but do not be too choosy; find a support group of other female colleagues; and do not take things too personally but face challenges with good humour and choose your fights carefully as there may be many. ■

Personality Traits in Leaders

Julius Neverauskas

Foreword by Ramunė Mazaliauskienė: **There are still some discussions that leaders, and especially successful leaders have certain traits in their character that sometimes are close to personality disorder. Is it so, or is it a myth - explains dr. Julius Neverauskas.**

There are findings that narcistic personality traits are higher in CEO's of the companies 5-10 time more often than in general population. A strong desire of power, an entitlement and grandiosity give these people high motivation to make a career and to strive for success. When supported by their self-confidence, a manipulative behaviour, and a dominance it often leads to high positions at work.

We know that there are many leadership styles. Narcistic personalities are prone to be an autocratic/authoritarian or paternalistic leader. These leadership styles are also typical for antisocial personalities. Sometimes narcistic traits combined with histrionic traits could help person to become a charismatic leader. Obsessive-compulsive personality traits are dominant in bureaucratic leadership style. Unfortunately, tendency to micromanagement in these personalities make their work less effective in a global sense.

Therefore, an effective leadership is something more than a managerial position. Leaders should have many qualities (vision, courage, integrity, strategic planning, positive attitude, cooperation, critical thinking, responsibility, flexibility) specific for a quite healthy personality. So, if persons have personality traits not prominent so much to be treated as personality disorder they could become and remain effective leaders. However, if they certainly have one or more personality disorders this often intersects with effective work in a leadership position. The inflexibility inherent in personality disorders prevents these people from being productive and effective leaders in a long run. Of course, there are some exceptions in a short time leadership during specific conditions, e.g. a war conditions when people who have personality disorders may act effectively but they just confirm the rule.

Difference between good leaders in crisis times and effective leaders in peaceful times? It depends what crises we have. During big and dangerous crises, especially in the beginning of them, an authoritarian and charismatic leadership style could be very effective. But later transformational, visionary, and strategic leadership styles often are better and more productive. So, a true leader is a person who is flexible enough to adjust to a changing environment and can modify rules. It means they must have quite healthy, open, and adaptable personalities. Fortunately, in democratic societies, it is possible to change leaders in elections and choose the best ones that are appropriate for the current situation. ■

Julius Neverauskas,
M.D., Ph.D., Head of Postgraduate Training Course in Psychotherapy (Cognitive Behavioural Therapy) at Lithuanian University of Health Sciences, President of Lithuanian Association of Cognitive Behavioural Therapy, President of Lithuanian Association of Mindfulness-based Psychology.

What is leadership in psychiatry according to young psychiatrists?

Jessica Gabin

Young psychiatrists in Norway obtain exposure to train and experience handling leadership through the numerous rotations in different clinical settings they obtain over the course of their psychiatric specialty training. Personal attributes often illustrate how good or bad situations can be handled, and many factors can either easily influence patients and the mental health team positively or prove to be challenging. I think many young psychiatrists typically find that being a leader themselves in a new clinical rotation is challenging professionally, but is an important attribute for young psychiatrists to develop so that high quality health care can be delivered.

Jessica Gabin
is a psychiatric trainee, and the current leader of the Norwegian Association of Psychiatric Trainees. She works at St Olavs Hospital in Trondheim, Norway.

Leadership in psychiatry is multi-faceted that aims to harmonize and incorporate psychotherapeutic principles and interventions into leading patient care. This is acheived through individual patient therapy, guiding mental health teams, and advising organizations within which they work. Psychiatrists often have a fundamental role in tolerating situations of considerable uncertainty. This is demanding on young psychiatrists, and expectations to therapy and treatment additionally comes from not only the patient but also next-of-kin and the health care team. Leadership should therefore encourage an open culture, where all sources centering around the patient are free to speak out about their concerns, and are supported by having a therapeutic arena to express their views.

In psychiatry, leadership also means advocating for patients to reduce stigma and ensuring that in-patient treatment bridges back to the community with optimal supportive care. Recovery and rehabilitation is a vital component in psychiatry that gives the patient an important role in leadership themselves—when indicated. Patients with psychiatric diagnoses feel more empowered when they are able to express their own views about their experience.

Leadership in psychiatry is a skill that all young psychiatrists can develop through training, reflective practice, and experience. ■

How to Regain Leadership of your Own Life? Inner Guidance of our Patients in the Process of Psychotherapy

Interview with Prof. Dr. Eugenijus Laurinaitis

Ramunė Mazaliauskienė

Hello, dr. Eugenijus. I am very glad that you agreed to talk about this very important topic – inner guidance of our patients in the process of psychotherapy. So, how could they gain the leadership of their own lives?

Maybe first we should describe or define what we understand by leadership in personal life. First of all, it is an ability to exhibit and keep an eye on moral and interpersonal principles in everyday life. This means that a person is able to actively promote and support these principles, not only in everyday behavior, but also in the surrouding life

People should act proactively when faced with unethical or criminal behavior. They should aim not only to be the leader of their own life but leader in life as such. This role is difficult, but there is no other way - without this skill and ability nobody can be a leader even in their own life, if they succumb to life´s dangers, complications, and stops pursuing their own values in the outer world.

How can you achieve this in the process of psychotherapy?

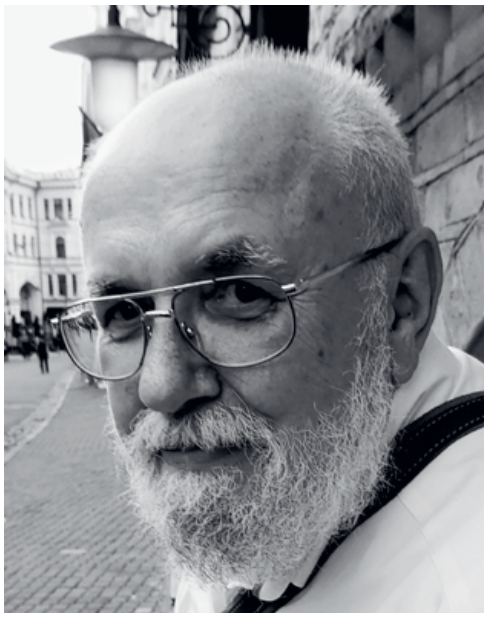
First, psychotherapy is about enabling the patient to change their life during therapy. This change aims to improve the patient´s biological, psychological and social functioning. When we are talking about psychotherapy, we must admit that this is a biopsychosocial specialty and it turns to influence all 3 levels of our existence. And when we are talking about the social life, this psychological feature of leadership in my own life is in a way transposed in our social functioning, so this is integrated - nothing exists separately, neither body nor soul in my own existence, so we are integrated in one entity and this ability to feel like a leader or an owner of my own life and to show that in my social interactions - it is of most importance.

And how we are doing that is by obeying our own principles. We may have inherited some from our family values. Sometimes we have them formulated by our life experiences. Sometimes we have found them in sources important to us during our development and maturation - the bible, books and so on - there are a lot of sources to find something new that has not necessarily been in my family or within my own experiences in life, obeying my rules.

The other thing is that one has to communicate these values of me and actual behavioral standards to others. This kind of communication may have two kinds of goals. First could be persuasive aims to promote change around myself and in my own life. Second could be effectiveness characteristics; that my words and texts are understandable, clear and prompted from the situation I am in. By communicating clearly about our values and behavior we accept responsibility. We accept responsibility for our words and actions. This is sometimes called honesty, but either way we must understand that it sits on our shoulders, this is our personality. This is the process of patient's development in psychotherapy, that helps to create the patient and their environment some basic characteristics of life -like trust. We may trust our own evolution; we may trust our relationships with important people around us and they can trust us even if we are changing the direction or a change is predictable.

How do you notice in your personal practice that the patient is already gaining the leadership in his or her own life? Are there any signs? How do you know it?

Generally, there are three stages of the change process. First stage is imitation - people grasp some important, valuable things from the conversations in psychotherapy, and



Eugenijus Laurinaitis
Assoc. prof. PhD Eugenijus Laurinaitis - psychiatrist, psychoanalytic psychotherapist, group analyst, founder of Individual psychodynamic psychotherapy course in Vilnius University (1993) and the leader of this course till 2017. President of Lithuanian psychotherapy association, president of European psychotherapy association (EAP) (2013-2015), General Secretary of EAP. Author of a few books and multiply articles.
Photo by Petras Vysniauskas

apply and use these things in their everyday life. And then when they come back to the therapy room they´ll say: "You know, I remember that you said that you should do this and that, and I tried. And you know what? It worked." That is imitation. Yet this set of values is still strange for the patient, he is only applying something that is mine.

The next stage is incorporation. That is, when a person does not know what I would recommend them to do in a specific situation, but when in this situation, they'll figure out themselves what I would probably recommend and then do that. There is much more authorship in this decision and action.

Finally, the third stage is identification. This happens when a person begins to make decisions in their life, outside of therapy hours, without any reference to the therapeutic process. He knows that the decision he's made is his own, and that is the best outcome a therapy can have. It means that the patient has matured for his own decision making in difficult life situations. So, that is the process. And when I listen to patient's stories of their life outside therapy and watch how they behave inside therapy - how independent they are of me - that way I am able to measure how ready they are to finish the work.

Last question – what personal qualities of the psychotherapist could contribute to this process?

First of all, they must be a leader of themselves. It is clear that you can not teach anybody something that you do not know. Second thing – an additional quality for therapist is tolerance, because when we are talking that the therapy is the process of the patient's change, we must understand that both the goal how far patient wants to go, the speed how slow or quickly he moves this way, the blocks in the processes of travel towards the goal are ruled on the part of the patient. And we can not pull them along nor push them to move quicker or in the proper direction – this is all on the patient's shoulders and therefore we must be patient ourselves. We must be tolerant to the patient's mistakes, to his somehow difficult paths that he has chosen to go, but all the time we must stay beside the patient. So, this is an additional, I would say not only professional but indeed the personal quality of tolerance.

Thank you! These were the questions from my side, maybe you would like to add something?

I would like to say that in my opinion and as an opinion of the European Association of Psychotherapy General Secretary that I am, psychotherapy is a separate profession. It has a separate theoretical preparation; it needs a personal preparation in the form of personal self-investigating activity, and it needs a special separate professional supervising inside the therapeutic work - not only in communication or contact work. So, this is my message to all therapists, those who hope to become therapists, all the colleagues who want to become therapists; this is a very interesting profession and a viewpoint to life and I do encourage you to take this journey.

Thank you so much! ■

Being a Chief Medical Officer

Interview with Ida Hageman

Marianne Kastrup

Having a clinical background may be an advantage in the work as CMO

How did you experience the step from a clinical consultant to a chief medical officer?

Previously I was focusing on the patient as an individual seeing the situation so to speak through the patient's lens, now I have moved the focus to populations, but I still retain a humility towards the complexity of the task that I have to fulfill together with others. I think that in my present position I need to see the situation from a global perspective.

When taking on the challenge as a CMO you have to be able to lift yourself from the single case to get the overall perspective.

Has the role of a CMO changed in your opinion?

Today we are faced with different conditions as the number of patients with mental disorders seeking treatment are increasing – in the capital region by 27% - but not with a parallel increase in the allocated resources which means that you try to manage in a situation where you have to balance to find the best possible solutions.

As a CMO you must accept that you may not always provide the optimal solution and endure that you manage with the best possible and defend that. I find it important to not only consider my own region but the overall perspective. (e.g. in relation to number of specialists) and to support solutions that may prioritize other regions. It is of utmost importance that your ego can accept that you do not win all battles and also that you are capable of distinguishing professional and personal criticism.

It is well recognized that psychiatric disorders are very complex disorders requiring a multitude of interventions which need to be faced in the forum of leaders.

In a survey by the Danish Medical Association many doctors replied that they experienced being allocated more and more administrative tasks. But it is important to distinguish administrative tasks of a purely practical kind (e.g. finding files) to tasks where strategies are developed and where medical input may have decisive importance.

Do you think there are advantages for medical organizations that choose leaders with medical backgrounds?

I believe that having a medical background has a number of advantages and that medical leadership deserves to be promoted. First, as a person with long clinical experience you are well equipped to set realistic goals. You are also well aware of what are the core tasks and I postulate that with that background you may be less prone to exert strong control but allow more autonomy

Ida Hageman
MD, Chief Medical Officer, Mental Health Services, Capital Region, Denmark

of your consultants. I also think that as a clinician you may be more realistic vis-à-vis the clinical reality. The British researcher Amanda Goodall who is a reader in medical leadership emphasizes that it is an advantage to be led by someone with professional knowledge in the field and mentions that at the Mayo Clinic in the US departments with medical leaders scored higher than those with purely administrative leaders. One reason being that you have a focus on what is essential for the patient even if you as a CMO have a population focus. Furthermore, as a medical leader it may be easier to create better, more sustainable relations when talking to colleagues as you yourself have been in similar situations.

Do you have any advice to give to younger colleagues?

You have to choose your battles carefully. It is also significant that you are not too perfectionistic and tolerate that not everyone has your standards. It is certainly also an advantage if you have a well developed sense of humor, and self-irony for not taking yourself too seriously. Such traits may help you to avoid becoming irritable and prevent burn-out. I also believe that it is a clear advantage having research experience – having worked so to speak with trial-and- error you understand the challenges medical researchers are confronted with and may be more willing to accept an innovative approach opening new horizons. Finally, some may have an inborn talent for leadership or a keen interest which may pave the way which I welcome. ■

Being a young leader in politics

Interview with Liban Sheikh

Siria Lemma

Liban Sheikh is a 31-year-old Finnish politician and the chair of the Left Youth of Finland. He studies social sciences in Tampere University and is a member of the Tampere City Council. In 2020 he was invited to participate in The Obama Foundation Leaders Europe six-month program.

How did you end up becoming the chair of the Left Youth of Finland?

I grew up in a working-class family in a small city in Eastern-Finland. Being black in a white society I experienced racism and social discrimination. These experiences, as well as economic inequality, are sometimes difficult to discuss. It might be that some of my interest in the world stems from those experiences. I have always been curious to know why the world is the way it is.

First, I ended up studying literature in Tampere University and from there I moved on to study social sciences because I had this longing to gain more understanding about the social structures that surround us. I wanted to be able to articulate more of the things I saw.

In university I got involved in student activities. I became editor in chief of our literature student magazine, acted as an event manager and eventually became a Student Union Council representative. One of my friends in the Student Union Council encouraged me to take part in the Left Youth of Finland and in 2019 I also became a candidate in the parliamentary election. In autumn 2019 I was chosen as the chair of the national youth league, Left Youth of Finland, and at the time became the first person of color to be elected as a chairperson in the history of Finnish political youth organizations.

Last spring, during municipal elections 2021, I got chosen as a member of the Tampere City Council and thus officially entered the "grown up" politics.

Has being the chair of the Left Youth of Finland met your expectations?

Yes, definitely! I have gotten to meet so many smart and warm young people all over Finland that share the same values and passion for equality. The community itself has been one of best things. This position has taught me so much about bureaucracy within an organization, about economics, administration and strategies. My position has enabled me to bring up or highlight some of the issues I find crucially important, such as environmental issues and equality. Yet one thing that has sort of surprised me negatively, has been the amount of aggression and hate-motivated behavior that people in the Left Youth of Finland face.

What are your views on leadership?

Leadership is often discussed in the corporate context. In corporate world efficiency and pursuit of profit play a key role, whereas in political context other goals are the essence. In youth politics our goal is to bring together young people and to enable them to become politically active members of the society. A political leader should aim to inspire, enable and implement. In the Left Youth of Finland, I have enjoyed the opportunity to practice value-based leadership.

Has your perspective on leadership changed?

Yes. As I have been working in anti-racist organizations and in the Left Youth of Finland, I have realized that leadership skills are as important in these contexts as they are in corporate world, just partially different. Thus, it is good to have some basic understanding of leadership theories. In anti-hierarchical organizations

we understand that one person will never give rise to change alone, it is the community that does that. I don't believe in putting people on a pedestal. In the end leadership is something that you learn by doing and growing, and I think an ideal organization consists of many people that possess some leadership skills.

I have also learned that when you are in a position of power it is important to consider how you talk to people you work with, when there are some difficult conversations to be had for example.

Do you have some leaders you look up to?

Yes and no. I admire many people for their different areas of expertise but not anybody specific.

What are you like as a leader?

Well, I think this should be asked from the people I work with. I aim to be an approachable leader that is fully present. I want to enable people to do their best, but I also want to make sure that people I work with will not get burned out. The aim is to create inspiring and healthy working environment together. As a leader I want to keep an eye on the big picture.

Are there some special features in being a leader in politics?

I have learned that in politics your working time is flexible. Some things may require immediate action and you must be available 24 hours a day. The work-life balance is something that is not really taught anywhere, and everyone must figure out some sort of balance between one´s working life and private life.

It might take a while to figure out how to combine this professional politician role and being yourself. I think that especially women and minorities struggle with this, since they often have to work harder to earn credibility. I've heard people say that I am much more laid-back and funnier than people would have expected, which I find both funny and sad.

How was The Obama Foundation´s Leadership program?

It was very interesting! We had some world-class lectures and both formal and informal conversations about leadership. I learned that there is so much that I can learn from other countries and people in other fields. The experience highlighted the importance of learning. I really like the Civil Rights Movement´s saying "each one teach one" because it sums up beautifully how you can always learn something from other people. Leadership is no exception, it is not rocket science, you learn it by doing and you learn from other people. ■

Liban Sheikh

Liban Sheikh is a 31-year-old Finnish politician and the chair of the Left Youth of Finland. He is a former Student Union Council representative in Tampere University. Sheikh studies currently social sciences and is a fresh member of the Tampere City Council. In 2020 Sheikh was invited to participate in The Obama Foundation Leaders Europe six-month program. The program is a virtual leadership development and civic engagement program that seeks to inspire, empower, and connect emerging leaders from across Europe. In his free time Sheikh enjoys fantasy and scifi literature.

Photo Pinja Nikki

Leading yourself

Finding my own career path

Laura Tenhunen

As children, we all have been asked what we want to do when we grow up. People expect children to give one answer, name one dream job. This idea of one career path causes a lot of pressure for young people when trying to choose the "right" field of study or work. Nowadays, since high school grades play a bigger role than they did a few years back, kids have to know at a very young age what they hope to do in the future. It is an impossible expectation. In reality, people´s interest may change as they grow. Similarly, as relationships between people, a person´s relationship with their job might last a lifetime or there might come a time when it is wiser to continue separate paths.

As a child I dreamed of becoming either a veterinarian or a nanny. Neither of those dreams became reality and, in the end, I ended up studying two seemingly very different fields. Yet, if you look closely there are unexpected intersections to be found.

First, I became a doctor. My parents did not encourage me to study medicine, nor did they advise against it. There aren't any doctors in my family. I attended a science focused high school and it might be that environment that influenced my decision making. I always enjoyed chemistry and biology, so going to medical school felt like a natural continuum. Yet during medical studies I longed to gain a broader understanding of the world and humanity. Even though I did not always enjoy studying medicine, I have definitely enjoyed my work as a doctor. Especially, I enjoy working in public health care because I get to meet people from all kinds of backgrounds. In that way work as a doctor offers a broader view of the society.

There is a lot of medical knowledge that you must possess as a doctor, yet our work is still essentially based on human encounter. Sometimes the human experience is complex and difficult to put into words. I always felt like medical school did not give enough tools for that kind of understanding. Doctors are anticipated to follow certain treatment guidelines, and good so. Yet sometimes when talking with a patient, it may feel like medical discussion alone is not enough to make the patient feel understood. I felt like I desperately needed new, different points of view, to gain more understanding of life as whole.

I think that art and humanity have always walked hand in hand. Philosopher James O.Young has stated: "Art can open deep insights into complex, multifaceted subjects like ourselves, our feelings, our relationships with each other, and our place in the world (Young, Art and Knowledge, 2000, p. 97)". Inspired by arts, I started to attend art history courses in the Helsinki

Laura Tenhunen
Laura Tenhunen is a specialist in general medicine. In addition to her work as a doctor, she studies in Master´s programme in University of Helsinki in Faculty of Arts. She is also a part-time wannabe drummer and a knitting enthusiast. *Photo Siria Lemma*

Open University, first in the evenings, but quite soon it escalated into full-time studies and eventually I got accepted to the Faculty of Arts.

In the beginning of my studies, I felt like I had betrayed my patients and my workplace and thought that my studies were kind of a break from "real life". During my studies, I came to realize that at the same time when there definitely is a need for people who put all their effort into one field to gain expertise in what they do, there is also a growing need for multidisciplinary and interdisciplinary perspectives and knowledge.

I feel like together medical school and film studies have offered me a really unique viewpoint to the world. In my bachelor's thesis I studied the representation of mental health problems in Finnish contemporary films and felt like I got to use knowledge from both of my professions. To be honest, I am studying arts because of my own personal interests, but I really think there's a lot in the art field that can also help me become a better doctor.

I feel lucky to have had the opportunity to create a professional path that looks like me. And of course, my path doesn't end here. Curiosity never ends, hopefully, and a person is never ready. I still have many dreams I wish to follow. One day I hope to become a psychotherapist and maybe through that, gain one more viewpoint to humanity. ■

About good leadership

Interview with Tobias Nordin

Hans-Peter Mofors

The big award, it came unexpectedly. In 2014, Tobias Nordin, then a 42-year-old chief of a large psychiatric clinic, received an award from the Queen of Sweden and was named the "Healthcare leader of the future". In the follow-up of this achievement, Tobias Nordin was offered several senior managerial positions, none of which he accepted. Instead, he chose to continue working to further develop his clinic. And three years later when he had achieved these goals, to everyone's surprise, he decided to step down.

The idea with this interview was to interview a well-recognized leader and chief in order to find out the secrets behind a successful leadership. Given the fact that Tobias had chosen to resign from a chief's position, I found it hard to know where to begin. What was it like leading a huge organization – and why did he stop?

As with so many other meetings these days, even this interview was conducted over video link. Tobias had just come home from Aalborg, where he works as a physician at a clinic for bipolar disorders. Our conversation alternated between then and now. In our dialogue, I notice that Tobias is a man who has reflected over his existence. His answers are precise, well formulated and anything but stereotypical.

-Becoming the head of a large clinic was never a thought or plan of mine, says Tobias. However, as a resident in psychiatry I often noticed how much my coworkers would complain about leadership. This did inspire my curiosity about what it would be like to lead an organization and if this could be done in a successful and effective way. Tobias' interest grew stronger and after completing his residency in 2006 he was appointed medical director and chief physician at a psychiatric department, at the age of 33. Three years later he became chief of the whole clinic.

-It was quite challenging and exciting from the very beginning. I wanted to make a difference in order to change the way psychiatry worked. From the beginning, I realized the importance of creating a strong team around myself. This is partly done by getting to know each other properly, and giving colleagues the right conditions to perform their work. To show understanding for peoples differing personal and professional capacities is crucial to achieve a well-functioning work environment with a common goal to strive for the best outcome. And also by conveying enthusiasm and inspiration.

What traits according to you characterize good leadership?

- Showing care for others is indeed a foundation in a good leadership. You must have the ability to put yourself in the situation of others. You also have to act as a role model, not only in theory but also in practice.

Receiving the award "Healthcare leader of the future" from the Queen of Sweden.
Photo Izabelle Nordfjell/Bildbyrån

Coworkers will do as you do and not just follow your words. In this respect, I took part in regular clinical work, even though it was not that much, it mattered. Furthermore, it is important to create a positive atmosphere and always emphasize the value of everyone's efforts in order to reach common goals. I also believe that it is important to listen to coworker's ideas and give them the chance to grow in their roles. It is of the utmost importance to communicate the context and conditions which all coworkers just relate to. And of course relating to a healthcare management who understand and trusts how the clinic is run.

Fewer and fewer physicians choose a career as a chief. What are your thoughts about this?

This is something that has varied over the years. In periods, the ability to lead has been given so much more importance than the medical profession itself. At other times, it has been considered important that the head of a clinic is both a medical doctor and a good leader. I do believe that doctors have something extra to contribute in leadership positions.

When everything was going so well professionally as a chief, why did you suddenly stop?

It was due to a series of different happenings. The award as "leader of the future" led to much recognition and with it, higher expectations, probably mainly from myself. In one way, this led to increased stress. Of course, it is nice to feel appreciation. However, I think that this led to me not going through with some of the changes in the organization that I had planned to do, such as introducing levels of leadership under myself. In the end, I had 35 chiefs who directly reported to me, and this was in an organization with 750 employees. As a result, I was actively involved in too many processes, which with time had obvious consequences.

I found it quite difficult with an increasing scrutiny from the media and other involved parties as I sometimes had to stand up for things I really did not support. And it didn't matter how I expressed myself, there were always some people who felt that I had not argued or defended them enough. That I did not take a clear stance on any particular issue. However, from my perspective, I could often see that all involved parties were right in their own way and had done things as they should. It was important to me to communicate the facts in a

Tobias Nordin
Works as a Consultant psychiatrist at a mood clinic at Aalborg University Hospital and at two out patient clinics in Sweden – Cereb and Tinamottagningen. He is 49 years old from Gothenburg and his activities besides work are spending time with the children, family and friends. Participates in seminars studying texts in the humanities and reflecting how these are associated with psychiatry and society in general. He also likes running, spending time at the gym and on the tennis/padel court.

balanced way, when the situation or issue at hand was a complex one. This was indeed quite difficult, and was often challenging to involve people in a constructive and fruitful dialogue.

Other reasons were that, despite leading the whole clinic, I felt increasingly like a small cog in a large wheel. The public system is often slow, making the entire process from idea to action a long and tiresome one. All too often it was not possible to carry out the ideas and changes that my colleagues and I found important for the further development of the clinic. For example, I wanted to increase the extent of out-patient services in order to reduce the need for in-patient care but this process took too long to implement. Also, I wanted more freedom to hire people I believed would bring value to the clinic even if the cost to the clinic would increase. This and many other plans did not come to fruition. I must however add that despite these obstacles we actually achieved in making major differences and were supported by the bigger organizational apparatus for this.

However, one day I realized that all was not well.

You suffered from stress. In what way?

Suddenly, I felt something was not right. I was involved in too much. My sleep was impaired and I started making mistakes, such as not finding things, showing up late to meetings and forgetting important matters. I even experienced somatic symptoms. For a long time, I asked myself if this was temporary and if there was anything I could do to remedy this. Maybe things would have worked out, but after 12 years as chief I felt that it was the right time to hand over the reins to someone else.

After so many years as a chief, how does one plan a future career?

After deciding to quit, I wanted to optimize the conditions for my successor to take over. I did not wish the clinic to suffer in this process, we had accomplished so much that it was important to keep the good work going.

I undoubtedly wanted to work as a clinician again. Actually, I had never had the chance to work full time as a doctor, since I became chief so early on in my career. However, continuing in the public system was not an alternative for me. As so often the fate played an important role. I was contacted by a company offering me work in Denmark. I thought, why not? You can only guess how nervous I was before taking on the new position in a different country. But this passed soon – and everyone was so welcoming. The time that followed was very exciting and brought me lots of joy. I learnt so many new things. Working abroad is indeed very rewarding. Working in Denmark is in many ways like working in Sweden, but many things are also different, not only the language.

At the out-patient clinic there are many colleagues with an academic background and there is a constant and creative scientific discourse. The hierarchy is more obvious than in Sweden and the chiefs do communicate in a more direct way that they do in Sweden which would probably never work in Sweden. However, I think that this structure brings the clinical work into focus and enhances cooperation between colleagues in a way that I find very liberating.

What advice would you give to a younger colleague who is considering a career in a chief's position?

Think and plan before you embark on a chief's career. Are the conditions right and do you have the right people around you? It is also wise to have an experienced mentor to guide you.

It is so important to be yourself, and not to "play the role" of chief. I believe that insecurity in this role may sometimes express itself in undesirable behaviors, such as being too authoritative. Dare to admit your shortcomings and always maintain a dialogue. And do remember that you can always leave the position if you are not happy with it.

Finally, what is it like not having the same level of influence you once had as chief?

At present, I feel no desire to lead again. I am most happy to work full time as a doctor. It is also nice and inspiring to see others lead, experiencing how they do it and evolve over time. Being a former chief myself, I have always told my superiors that right now I am happy being just a coworker. I am however always ready to share my experiences of leadership if and when asked. This has then happened on several occasions, and I believe that they have been fruitful and constructive conversations. ■

Leadership: the voice of young doctors

Kristina Norvainyté

LEADERSHIP IN ANY FIELD should always start with self-leadership which encompasses self-awareness and self-management, constant drive for improvement and personal integrity. A great leader has a strong sense of responsibility for everything that's happening around which translates into complete ownership of his or her life. They are visionaries who can inspire others while voicing and enacting strong personal values. Building on these attributes, great medical leaders are not only strong academically and clinically - but they are also health advocates as well, making it their responsibility to endorse culture of health. That's why medical leadership specifically requires one to have a deep understanding of political, economic, technological, and social aspects of the healthcare system. The list of skills goes on, however, seeing how rapidly healthcare system changes and considering its complexity, it appears that medical leaders all over the world must take their time learning about the principles of change management while keeping up with the practices for stress resilience. ■

Kristina Norvainyté
M.D., is a fourth-year psychiatry resident in Lithuanian University of Health Sciences. She is a President of Lithuanian Junior Doctors' Association and a member of Lithuanian Junior Psychiatrists' Association.

Leadership in medicine

Ieva Everte

LEADERSHIP IN MEDICINE in my view is working in a team, noticing where others need a helping hand and reaching out; being creative and making paths where there are no visible paths; noticing system errors and working towards fixing it; creating opportunities where there seems like there aren't any; being persistent and doing the best work possible for patients and colleagues; encouraging colleagues in difficult times, helping push through; growing knowledge daily and helping others to do the same.

Being a good doctor and a good leader can very well go hand in hand, one doesn't exclude the other.

In my professional life I have already had great opportunities and I have met some great leaders & doctors in our own country and abroad. We get to know who they are when we see how they care for the work they do, how they push others forward to achieve more, when we see them do amazing work and changing the system, changing the known for better. ■

Ieva Everte
is a resident doctor in psychiatry and team leader of the Latvia Psychiatric Association Young Psychiatrist section. She is passionate about psychiatry, psychoeducation and incorporating evidence-based principles in our daily well-being routine.

Ready for Leadership

Interview with Ida Maria Ingeholm Klinkby

Marianne Kastrup

Competence in leadership and professional skills are important for future psychiatrists. Courses in developing such talents are welcomed.

Ida Maria Ingeholm Klinkby
is a child & adolescent psychiatrist-in-training at Child psychiatric unit, Roskilde Region Zealand. She is the vice-chair of the Danish Association of Young Psychiatrists.

Do you think that young psychiatrists at the end of their specialization are sufficiently competent to take on a leadership position?

During our specialization we are offered a 3-module course on the organization of health services focusing on organization and leadership. Parts of the course are more theoretical but module 3 focuses on your own personal style. We carry out group work with a focus on leadership styles and are exposed to a personality test.

I enjoy exposure to leadership roles. As child & adolescent psychiatrists, we are not given jour function (bagvagt) during our training before reaching specialization, in contrast with our colleagues in adult psychiatry who are given that role rather early and thereby challenged with leadership decisions in their daily clinical function.

The training in how to take on the leadership role is not very formal, even if you express an interest in having that role. On the other hand, working in an outpatient clinic, the role as team-leader is obvious with ample opportunities to try leadership and see if you feel confident in taking it up.

Are leadership positions attractive or do many avoid them?

I think that it depends upon the individual, but surprisingly it is frequently a taboo to express an open interest in becoming a leader. Few state that openly, whereas many are reluctant if not directly uninterested in taking up such positions.

The president of the Danish Medical Association who clearly has taken this challenge and subsequently been confronted with accusations of sounding too much like a member of administrative/economic management. You walk on the knife's edge frequently as a medical leader.

What professions have you encountered as being leaders of psychiatric departments?

In my last position we had an economist as the administrative chief but with 2 psychiatrists as clinical leaders. There may be advantages having an economist as head in light of the many economic, and strategic tasks as long as the clinical leaders with medical expertise have strong positions. I am less in favor of having psychologists chairing units. I have experienced departments where 3 out of 4 team-leaders were specialized psychologists with the result that medical and somatic aspects were not sufficiently focused upon. I find it important to emphasize that medical doctors should have the overall responsibility for the treatment carried out.

I also find it important to stress that it is psychiatric care not mental health care (psykisk helse værn) that is our focus.

Do you see a danger in a trend where medical core tasks are partly replaced by other, more secondary tasks?

Yes. In the last issue of the Journal of the Dan Med Ass a psychiatrist described his daily work how he as a consultant only saw one to two patients daily as his schedule was filled with all kinds of other tasks e.g. administrative, educational duties. This may result in that fewer want to enter the specialty as non-medical tasks take up most of the day. I see that as a real threat for the profession.

Have you come across any good initiatives?

One region of Denmark offers a course for psychiatric leadership talents, where young psychiatrists expressing an interest and talent for leadership are given the opportunity to become better equipped to take up the role. This is an innovative step to be preferred for already existing courses where participants come from all disciplines but with no medical priority. ■

Leadership and professional skills courses

Interview with Norman Sartorius

Marianne Kastrup

Young psychiatrists rarely receive adequate training in leadership and professional skills that would make it easier for them to manage their tasks in the different professional roles of a psychiatrist. The courses described below help to fill that gap.

When did these leadership courses start and why did you take the initiative to start them?

The courses started modestly, in the 1990's because I had many opportunities to see that young psychiatrists frequently faced difficulties because they were lacking professional and leadership skills. Gradually the courses became more popular and developed into their present shape. The courses last 3 days with an intensive program of 10-12 hours a day. We found that although strenuous, an intensive work schedule creates a better atmosphere and facilitates networking and building of friendships which is also an important goal of the courses.

Norman Sartorius:
Professor in psychiatry, former director Mental Health WHO, former president WPA and EPA.

The courses have taken place all over the world from China to Mexico and Indonesia each bringing together participants from neighbouring countries. We also have annual courses in Japan (various towns) , India (Bangalore) and Germany (Berlin). Since its inception we have given more than 130 courses with a total of some 2500 participants.

We usually receive 4-6 applications for each of the 16 seats. Each applicant sends a cv and a detailed letter of motivation. Subsequently these are assessed by a local expert, the course co-leader and myself, and then a final decision is made taking also into consideration geographical and gender distribution.

What is the objective of these courses?

I had myself the experience that no one taught me very simple things related to my daily work. Professional skills that would have eased my work and development and saved me a lot of trouble and time were simply not taught. Remembering this I have created a model for the course that is focused on needs emerging on daily work - making participants

acquire relevant professional skills – for example how to present oneself, how to present a proposal or a paper, how to say no when faced with extra workload, how to negotiate or how to choose the first research topic. In most courses I have also had the invaluable support from one or two very experienced colleagues (Graham Thornicroft, Ida Hageman, David Goldberg, Mohan Isaac, Andreas Heinz to mention a few).

Participants are typically kept very active, asked to present papers, develop proposals (and learn how to present them) take part in role plays of typical work tasks, learn how to evaluate, and present their evaluations of work in a constructive manner. They are given practical advice about the selection of research topics, about publication. They learn how to speak to public health authorities, how to manage a small team and how to manage their time.

How are the courses financed?

We have limited resources. We have over time received some funding from pharma (without ever accepting to promote the donor or their products), and some university funds, but a lot is self-financed by participants. Teachers receive no honorarium, just have their expenses covered and the participants often pay their own travel expenses and accommodation.

Do you have information about the impact of these courses?

We carry out immediate evaluation after the course, but I receive later significant feedback from former participants how the course had changed their career and how useful they have found the exercises. Many recommend to colleagues and friends to apply for the course which I consider to be a very positive evaluation. Of course, there is a bias in these assessments as those participating are not a random sample of young psychiatrists but a selected group which volunteered to actively participate in a strenuous course – a group that would have probably managed well irrespective of the course but might do better because of it. Right now, a group of former participants is planning a survey of short and long-term gains from courses and of their impact on their career-patterns.

Do you see advantages of having psychiatrists in leadership positions?

I do. We undergo minimum 12 years of training after leaving high school, so we gain a lot of experience and have our performance observed for years in contrast to others who may be given such positions. I believe that substantial professional experience is a clear prerequisite for assuming leadership positions in our field. It would be wrong to underestimate professional competence and experience in selecting leaders. ■

Leadership and Personality Disorder: what do we know?

Interview with Rima Viliūnienė

Ramunė Mazaliauskienė

Some researchers talk about certain personality traits or - sometimes- even about personality disorder. What do you think: can a person having a personality disorder be an effective leader? If yes, what type of disorder, and in what way?

I want to share a few ideas from "Handbook of Leadership Theory and Practice" Chapter 7 A CLINICAL APPROACH TO THE DYNAMICS OF LEADERSHIP AND EXECUTIVE TRANSFORMATION by Manfred Kets de Vries and Elisabet Engellau as I thing it could illustrate the topic. "The study of leadership is difficult because (as one wit said) **leadership is like pornography: hard to define, but easy to recognize".**

True leaders are merchants of hope, speaking to the collective imagination of their followers, co-opting them to join them in a great adventure. Great leaders inspire people to move beyond personal, egoistic motives - to transcend themselves, as it were - and as a result they get the best out of their people.

The essence of leadership is the ability to get people voluntarily to do things that they would not otherwise do.

A solid dose of narcissism is a prerequisite for anyone who hopes to rise to the top of an organization. Narcissism offers leaders a foundation for conviction about the righteousness of their cause. The leader's conviction that his group, organization has a special mission inspires loyalty and group identification; the strength (and even inflexibility) of the leader's worldview gives followers something to identify with and hold on to.

The combination of narcissistic disposition and the pressures of a leadership position can have disastrous consequences. The challenge is how to keep sane people sane in insane places.

Constructive narcissists <…> are not searching for personal power alone. Rather, they have a vision of a better organization or society and want to realize that vision with the help of others. They take advice and consult with others, although they are prepared to make the ultimate decisions. As transformational leaders they inspire others not only to be better at what they do, but also to entirely change what they do.

Reactive narcissistic leaders, <…> as a way of mastering their feelings of inadequacy and insecurity, they may develop a sense of entitlement, believing that they deserve special treatment and that rules and regulations apply only to others. They may develop an exaggerated sense of self-importance and self-grandiosity and a concomitant need for admiration.

Many reactive narcissistic leaders become fixated on issues of power, status, prestige, and superiority. To them, life turns into a zerosum game: there are

winners and losers. They are preoccupied with looking out for number one. Reactive narcissistic leaders are not prepared to share power. On the contrary, as leaders they surround themselves with yes-men. Unwilling to tolerate disagreement and dealing poorly with criticism, such leaders rarely consult with colleagues, preferring to make all decisions on their own. When they do consult with others, they expecting others to agree to whatever they suggest."

R. M. What are the personality traits of an effective leader in crisis times? Do good leaders in crisis times differ from effective leaders in peaceful times?

R. V. In the wartime they command (lead) us, but in the peacetimes we imprison them. I don't remenber who is the author of this idea. Sad, but true.

In a crisis, a leader is needed to take on the role of messiah / savior. After that, when the crisis ends and the next stage of the organization's development begins, there are often challenges in changing the leader-messiah to a different type of leader. Because a narcissistic or psychopathic leader refuses to be replaced.

Rima Viliūnienė,
MD, PhD, is a psychiatrist, a psychodynamic psychotherapist in private practice, assoc. prof. at Clinic of Psychiatry, Faculty of Medicine, Vilnius University (Lithuania).

Connecting with other cultures

Lars Lien

The new president of the Norwegian Psychiatric Association has personal long-term experience as a doctor in quite different cultures than his origins in the sturdy Norwegian inland, both Finnmark in the far North and Namibia in Southern Africa. Here are his reflexions.

The interest of culture should be on the forefront of every psychiatrist. The definition of culture is broad and Fredrik Barth formulated culture as the ballast of ideas and norms that a person carries with him/her based on what the person has learned and experienced that is his/her knowledge, conventions, opinions, attitudes and values. According to Segall, culture consists of learned opinions and common information that is transmitted, often somewhat changed, from one generation to the next through interaction.

So why should we care about culture in our everyday work? The simple answer is that all people that we get to meet in professional contact have a cultural background that should interest us if we want to provide good care. Several studies show that we tend to give the best treatment to people that have the same background as ourselves, concerning educational level, way of living and worldview. The further away from ourselves the person is from our own background, the more challenging it is for us to offer good treatment. Yet we seldom recognize this blind spot.

Differences in culture do not need to be someone from a different country or with another language and ethnic background. People with less education, different dialects and from other parts of our own country might pose a huge cultural barrier to adequate treatment. The problem with cultural ignorance and bias is that we don't acknowledge our own prejudices. The best way to connect to other cultures is therefore to admit and accept our bias towards cultures and to be more curious about the cultural background of any person we meet in therapy.

So, is there specific knowledge we could learn to better connect with other cultures? Studies showing differences between the west and the rest do not lead us any further as this is often black box epidemiology where we put people with many different cultures into same group without the possibility to find useful differences. Just as a beginning, we should evaluate if the person in front of us is from an individualist versus collectivistic culture. This will have an important influence on the way we involve the family and wider society.

What else should we aim to be interested in from a cultural perspective? Family roles and organization of the family, who is head of household and which gender roles are expected in the relevant culture. Further, we should explore dominant language and the cultural communication patterns, heritage, spirituality and rituals connected to childbearing and death. Taboos and specific high-risk behaviors are also important together with perceived discrimination and stigmatization.

The Cultural Formulation Interview (CFI) is a very powerful tool to assess all kind of cultural dimensions of all patients. CFI has 16 questions and was first published as part of DSM 5 and fits very well in as a first assessment of any patient. Otherwise, we should assess possible language barriers, stigma connected to seeking psychiatric help, emotional restraint, avoidance of shame and social harmony adjustment. To provide for anonymity is especially important for people from other cultures and the use *of* translator might be a problem where there are few people speaking the specific language.

To ease the use of mental health facilities we should try to collaborate with ethnic organizations and establish psychoeducation groups. We should look at the staff composition in our clinics and if possible hire qualified staff with a diversity of ethnical background, as seeing staff of the same ethnic background may dramatically increase patient access and initiation into treatment. In addition, if

the treatment provider is not of the same ethnic background, it is best that he or she take on an inquisitive role and not make any ethnocentric assumptions based on his/her own cultural heritage as mentioned above. The goal of the clinician should be to uncover sociocultural issues that will affect acceptance, retention, and ultimately, treatment outcome.

One way to better understand how it is to be a part of the minority population is to travel or work in parts of the world with another culture than your own. From my own experience, I have tried to live and work in different cultures both within Norway and other countries. After graduation, I worked for three years in a fishing village as far up north in Norway as it possible to get. To learn about the historical hardships of getting food and to survive in an artic climate was an experience that was important in the contact with the patients.

For five years now, I have been working as a psychiatrist in Karasjok, which is the hearth land of the indigenous Sami population in Norway. Again, it is important to know the culture with the strong tradition of reindeer herding, but also their roots as a strongly discriminated population where the majority population almost eradicated their languages. The Sámi Klinihkka in Karasjok is now offering both somatic, addiction and mental health services to not only the Norwegian, but also the Finnish and Swedish Sami population.

Lars Lien
is president of the Norwegian Psychiatric Association and adviser to the National Competence Service for concurrent substance abuse and mental illness (ROP). He is a specialist in community medicine and in psychiatry and took his PhD in 2003 on a study of risk factors for mental health problems in adolescents with an immigrant background. He participates in and leads various research projects with topics ranging from health care research to basal neurobiology. He is affiliated with the Department of Health and Social Sciences at Inland University College as Professor and is consultant physician among the Sami population and Professor II at the Arctic University of Tromsø.

Conclusion:

The patient you meet may have a different culture than yourself despite the fact that you have grown up in the same place and belong to the same ethnic or cultural group. Becoming culturally conscious is a process that starts by reflecting on one's own values and how these are socially constructed. ■

“Best to quit while someone still misses you”

Interview with the CEO of Landspítali National University Hospital

Óttar Gudmundsson

Why did you become a manager?

Actually, this was a coincidence. I have always wanted to be near the patient and to solve his problems in many ways. Most physicians practice micro-medicine, sitting by the patient alone, talking to one at a time and trying to make him change his life. Those who do not find this to be sufficient move over to meso-medicine in order to reach a larger group of patients that way. Then there is the macro approach, where the physician assumes control of a hospital or of a whole healthcare system, and thus tries to improve the life of the patients through the auspices of the institution. I wanted to have a greater impact than I could through seeing individual patients, which is why I initially applied for management positions within healthcare.

Have you always been a determined person?

Yes, and I wanted to realize my opinions. This means leaving the bench in the staff canteen. Just moping about in the canteen, complaining and criticizing without a will to get involved, is not my thing. As it happens, the canteen naggers are totally useless. They have nothing to contribute and are not members of the team. One must be prepared and ready to roll up ones sleeves and thus make a difference.

How did running the psychiatric wards go?

I managed to achieve various things. The principal issue is serving the patients. My professional background is psychiatric intensive care, forensic psychiatry but on the other hand also community psychiatry. I established a PICU, transformed forensic psychiatry and also started a few community psychiatry teams, including assertive community treatment (ACT) teams, an early onset team and rehabilitation support. Through these service improvements we succeeded in reducing the number of inpatients. Psychiatric wards of university hospitals should not tend to all patients; instead only those needing specialized services, at the same time building bridges into the community.

Psychiatrist, Páll Matthíasson

Psychiatrist, Páll Matthíasson, has been the CEO of the Landspítali National University Hospital in Reykjavík (LSH) since 2013. He has now resigned from this position and moving on to other fields. Prior to this position, Páll was the head of Mental Health Services at LSH from 2009.

Are you innovative?

I have always been attracted by new things and have certainly not feared trying something new. During my studies in the UK I was always prepared to participate in new teams or some other experimental activity.

Should physicians be managers?

Yes, the physician possesses an overview and knowledge that serves him well in administration. Nevertheless, he must conduct himself in the best manner for

serving the interests of the patients, and must also have a strategy to offer.

What symbolizes a good manager?

I like the theories of Patrick Lencioni. He talks about three principal factors a good manager must possess, i.e. hunger, humility and being smart. He needs to be hungry, i.e. he must want to do good and perform well and skillfully. He needs to be smart, namely possess knowledge and understand well the relevant activities. Having a manager who is constantly hesitant is very uncomfortable. Last but not least a good manager needs to be humble and able to work with others.

Humility?

Yes. Arrogance is a characteristic that badly suits managers. Management is teamwork, involving the know-how of several people working together. People must be able to conduct themselves as equals within such a system. A hospital is indeed a complex system and one must be prepared to make and admitting mistakes. The manager must look ahead in his complex activities, generally on grounds of limited information. This was indeed very apparent during the Covid epidemic where people stumbled about in darkness and frequently had to make fateful decisions very promptly. Humility is a necessity in such circumstances, one must admit how one does not know everything yet at the same time having to make decisions on grounds of incomplete information. Then there are circumstances where a backwards step must be taken. The manager cannot allow himself to be obsessed by the need to be perfect, as this makes him hesitant in an unclear and constantly changing environment.

What characterizes a bad leader?

Decision fetish and fear of taking a stand. A leader who is not prepared to enter into decisions and take measures is equally as bad as the physician who is not prepared to diagnose and launch treatment of his patient.

To what extent has your expertise in psychiatry helped you as CEO?

Having this background has served me well, in fact I am of the opinion that the hospital CEO should have a health education background. The operation of a hospital is highly complex and various matters materialize where expertise is necessary in matters of disagreement, and also the leader must lead and to do that you need a well grounded vision. The psychiatrist is trained in difficult dialogues and knows how to treat people respectfully. The psychiatrist generally knows the dynamics of group therapy which in turn is helpful at meetings. Having a working knowledge of transference and countertransference is good for understanding the interaction between the staff. Everyone has a role one should be able to define. Withdrawing from the position I held has come easy to me. Conflicts have not affected me much, as I do not define attacks against me personally; instead it is against the office I hold. Every psychiatrist is experienced in separating himself from his professional work.

What about general judgment of character?

Understanding the human and his emotions constitutes a part of the knowledge and development of the psychiatrist. Then knowing concepts like happiness and reconciliation, burnout and resilience helps the psychiatrist in his work.

Have you had management training?

Yes, however, I find the education and experience in psychiatry to be more significant. Management theory is not a very complex field and although more than one hundred thousand management books have been written, the most practical theories are easy to understand -yet hard to implement.

You are retiring from the directorship. How does this feel?

I proudly look back. This is a workplace of 6000 people and assessing the results is difficult, but nevertheless, I feel as having achieved much.

Do you feel unfairly criticized?

Not me, however, the hospital has been very unfairly criticized as people do not take into account the complex overall picture running a hospital represents; instead people tend to focus on a small part of the activities and then pass judgment on such grounds.

Why quitting?

Best to quit while someone still misses you! ■

Translated from Icelandic by:
Ellen Ingvadóttir
Court Interpreter and Authorized Translator, EU-ACI

Does Good Leadership Prevent Mobbing in the Institution?

Interview with Jolita Vveinhardt

Ramunė Mazaliauskienė

Recently, there has been quite a lot of discussion in Lithuania about mobbing in healthcare institutions. Long-standing traditions of mobbing in the medical system, the formation of inappropriate climate in the entire healthcare system are discussed. In such context, we turn our attention to managers of institutions. What does the manager of the institution "need" in order to be a leader too?

J. V. Just to be a human. With shortcomings and advantages. Not a superman. The superman cannot improve. A self-critical leader will always look for what he has not done. Look for where he has made a mistake. Poor psychological climate and mobbing always signal leadership mistakes. This is an axiom. There is a lot to be said about the leader's qualities and which of them are needed, but the first step is to recognize one's shortcomings, imperfection. Then, a positive emotional climate can be sought. As to mobbing, on the one hand, the good news is that we are talking about it more openly. On the other hand, I sympathize with managers because often the manager already fears to demand more strictly or make necessary decisions. That should not be the case. Some employees manipulate the term mobbing to cover up their responsibilities, others use it to refer to any unpleasant experiences in employment relationships. The distinction between those things requires training.

It is sometimes said that the manager should not be empathic, allegedly this improves making unpopular decisions. What do you think about this?

First, research shows that successful leaders differ from less successful ones by more developed empathy. Its absence makes it difficult to maintain healthy relationships with subordinates and communicate effectively. If employees feel being valued, understood, if their needs are considered, usually they reciprocate. They trust and are more dedicated. This is important when it comes to making necessary though unpleasant decisions. If a surgeon is cutting a gangrenous leg, that does not mean that he is completely indifferent to the patient, right? Contrary to what is sometimes thought, empathy helps

Jolita Vveinhardt
is a professor, researcher of destructive interrelations among employees, working at Vytautas Magnus University (Lithuania), WSB university (Poland) with a PhD in management. She pays most attention to the victims of workplace mobbing, advises organizational leaders and HR professionals on how management tools can be applied to eradicate the particularly dangerous disease of modern organizations.

to perceive the consequences of the decision, to prepare people, and to help them cope with inevitable changes. Trust in the manager is of major importance in this case. Besides, if the manager lacks empathy, he will give prominence to himself and devalue employees, will not love the organization, will not be dedicated to it and its people. Such organization will remain in mediocrity, despite the manager's professional competencies. Undoubtedly, this is a great and necessary feature.

What happens in the institution whose manager is not a leader?

J. V. Being a leader does not guarantee that mobbing will be avoided because it is also important what kind of leader you are. There must be sufficient control in the organization, which cannot be guaranteed by, for example, laissez-faire style. In general, passive style provokes ambiguity in employee roles and role conflicts, causes numerous stressful situations that are a favourable medium to mobbing. Lack of tools, information, time to complete tasks, clear instructions, control leads to ignoring conflicts or postponing their decisions, intimidation of subordinates – all of it also negatively affects their interpersonal relationships. Sooner or later, an explosion will occur. I see still another problem: often the institution managers' position is taken by excellent professionals in their field, but they lack managerial knowledge and abilities to organize processes. This can be acquired. There are managers who understand this and often it is sufficient to introduce low-cost reorganisations. Lack of some distinctive, strongly expressed leadership traits does not hinder to create a safe, employable environment if you know well what you are doing. Maybe the organization without a bright leader will not achieve amazing results, at least it will be safe to work in it, it will not suffer financial and image losses guaranteed by mobbing.

What could the ideal manager-leader of the institution that is "unfavourable to mobbing" be like? What are the main tasks of the manager – leader – of the institution in shaping the atmosphere in the institution and creating the environment that is intolerant of mobbing and favourable for employees?

J. V. I avoid the word 'ideal'. This is never the case in life. We strive for perfection, ideality, but we still die imperfect. Of course, that does not mean that we do not have to look for ways to become better employees, managers. Various studies show that leadership style surely pertains to the quality of employees' interpersonal relationships, conflicts. At least two types of leaders who are more successful in creating the environment unfavourable for mobbing are distinguished. These are transformational and transactional. There is no unanimous agreement which is "better" here. Both have advantages and disadvantages. In any case, it is important how successfully they manage to create a positive moral atmosphere, reduce overall stress levels, uncertainty, role conflicts, and ensure process monitoring. Predators hide in turbid water. The more transparent the water, the less it is muddied by the manager himself, the safer the employees feel. ■

Mogens Schou, the lithium pioneer

Per Vestergaard

Only a handful of Danish psychiatrists have achieved international fame and foremost among them is Mogens Schou (1918-2005), former professor of biological psychiatry at Aarhus University and the father of modern lithium treatment.

Mogens Schou was born into psychiatry. His father, Hans Jakob Schou (1887-1952) was the director of "The Philadelphia Colony", a large, rather unique, private institution in the countryside, where patients with epilepsy and mental disorders were treated. Mogens Schou was introduced to the distinguished psychiatrists, clinicians and researchers, who visited his father's institution, he became familiar with the patients on the premises and he discovered the heavy load of mental disorder which haunted his own family. This upbringing formed his future career. He chose to study medicine and after training in Denmark and abroad, in 1951 he joined as a research assistant another famous Danish psychiatrist, professor Erik Strömgren (1909-1993) at the Risskov Psychiatric Hospital in Aarhus. Erik Strömgren encouraged his new assistant to study the clinical effect of lithium on manic patients. Strömgren had just read an Australian paper by John Cade (1912-1980) on this subject and found the prospect promising, although the paper was lacking in methodological rigor. Mogens Schou planned the first ever double blind, placebo controlled study in psychiatry and proved a superior effect of lithium. The paper was published in 1954. After this time Mogens Schou dedicated the rest of his long life to the study of lithium, the clinical effects and the pharmacological properties. He was appointed professor of biological psychiatry in 1972, resigned in 1988 but remained enormously productive until his death in 2005. Altogether he produced more than 600 papers, all of them related to the importance of lithium in psychiatry.

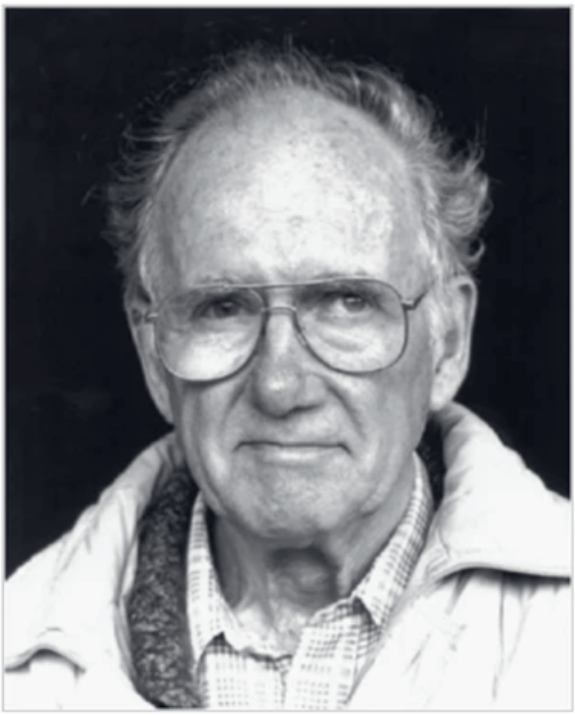
Mogens Schous most important scientific achievement without doubt is his demonstration of the ability of lithium to prevent manic and depressive attacks in manic-depressive patients. Through the 1960-ties and 70-ties he published, together with Poul Christian Baastrup (1918-2002), a number of papers on this subject, but was met with doubt and suspicion from international colleagues, especially from the famous Maudsley Hospital in London. Schou and Baastrup won the contest and from 1980 no serious doubt was raised about the efficacy of lithium treatment for the prevention of mania and depression (although occasionally new attacks do emerge).

Per Vestergaard
professor emeritus, Aarhus University

Mogens Schous clinical contributions were published in collaboration with clinicians outside Aarhus: Poul Christian Baastrup working in Copenhagen and Paul Grof (1935-) settled in Canada, just to mention the two most important. The work in Schous own research department in Aarhus mainly concentrated on the pharmacokinetic properties of lithium, an extremely important subject because of the dangerous renal side effects and the risk of intoxication. The mapping of the renal handling of lithium led to important instructions for the safe administration of lithium and the prevention of intoxication. Much of Schous later years was spent with repeated lecturing all over the world with the purpose of instructing yearning colleagues. Also the confidence of the manic-depressive patients was at his heart. To this end he wrote and rewrote a short instruction for lithium treated patients, a book that kept coming in still new editions and in still new translations.

Mogens Schou was a modest and hardworking man, dedicated to serve his patients, his colleagues and his students. He was impatient, but he did not stop up before the manuscript he was working on was perfect, short and concise in elegant and correct English.

Mogens Schou died at the age of 87 - with a newly finished manuscript in his computer - a few days after returning home from a conference in Poland, where he had lectured. He was the father of modern lithium treatment and a pride for his colleagues and for his country. ■



Mogens Schou 1918-2005

Psychiatric Hospital in Covid Times

Interview with prof. Arūnas Germanavičius, director of Republican Vilnius psychiatric hospital

Ramunė Mazaliauskienė

Foreword by Ramunė Mazaliauskienė: **In Lithuania, as in many countries, mental health system including mental hospitals had to be reorganized to correspond the requirements of the pandemic times. Vilnius Republican Psychiatric hospital, the biggest mental hospital in Lithuania, met the challenges, and now, after some time, it is time to conclude what was done, how it was done, and what are the consequences.**

During the covid pandemia what were the initial changes in the hospital and in services? Have you closed or reorganized some of the departments or services?

Republican Vilnius psychiatric hospital (RVPH) is the biggest psychiatric hospital in Vilnius region (Lithuania), serving for the catchment area of approximately 1 mil. inhabitants.

The full capacity is 402 psychiatric beds covering the whole spectrum of age (from child and adolescents department with 12 beds, to gerontopsychiatric service in the department for treatment of Alzheimer disease and somatopsychiatric conditions with 25 beds. However, the real occupation of inpatient beds in 2020-2021 was 270 patients treated each day, with providing psychiatric consultations and admissions 24/7. In 2020 we have treated about 5000 patients.

Since the beginning of COVID-19 pandemics in March 2020, the decision was made to reduce planned hospitalisations, day-care unit, and psychosocial rehabilitation activities temporary. Old age psychiatric department (gerontopsychiatric) patients were gradually discharged for 30 days, and the department was re-organized into the short quarantine department for acutely admitted patients waiting for two PGR tests in-a-row. Also, we have divided acute admissions into two flow lines regarding epidemiological risk. At the admission department triage of nurses was introduced, trying to assess risk (contacts, temperature, signs of infection etc.), and after the triage patients were referred to: 1) patients with small risk for contact with COVID-19 infected persons, and 2) patients with high risk for infection with COVID-19.

In our hospital we have intensive somatic care unit with ventilators, oxygen supply with 6 beds, so we divided it by half, and 3 beds were made available for COVID-19 patients with psychiatric conditions, who require ventilator or intensive oxygen therapy or cardiopulmonary monitoring 24/7.

Also, department for acute psychoses with 14 beds was transformed into COVID-19 department, where oxygen concentrators made available for patients on demand.

Because our hospital is tertiary university level specialized hospital, we receive many patients with treatment-resistant psychiatric disorders, so neurostimulation (ECT, TMS) is provided in accordance with indications and the treatment protocol. During COVID-19 pandemics, we had to interrupt ECT provision for COVID-19 infected psychiatric patients, who have had psychiatric conditions resistant to psychiatric treatment, because of the shortage of anaesthesiologists, and scrutinized this high risk for COVID-19 infection of staff procedure and appropriateness of protective measures. However, since July 2020, we resumed ECT also for COVID-19 infected psychiatric patients, and continuing until now, covering the need for many patients from the whole Lithuania.

Arūnas Germanavičius
is a professor in social psychiatry, and a 6 year delegate of Lithuanian psychiatric association in Nordic Psychiatric associations. He is the director of Vilnius Republican Psychiatric hospital.

Were these changes temporary or they still persist?

Department for gerontopsychiatry is still closed, and instead of it short quarantine department for acutely admitted patients waiting for two PGR tests in-a-row. Because pandemic continues, we keep divided acute admissions into two flow lines with regard to epidemiological risk. However, day-care, psychosocial rehabilitation and planned hospitalisations are provided since January 2021 without interruptions.

What was the reaction of staff to the pandemic work reorganization? Have you lost some staff because of this COVID-19 situation?

Yes, this was the most tragic consequence for the hospital: there were about 30 staff members, belonging to age group 55-65 decided to leave hospital during first 4 months fearing for their own health and safety. Also, we lost some head psychiatrists of departments, because of psychological burden of reorganisation and necessary rotation of medical staff, while some departments were temporary isolated due to internal COVID-19 outbreaks. During two waves of pandemics in 2020, about 15% of all staff members got infected with COVID-19, but fortunately none has died. Later, when vaccines were available, and about 62% of staff got two jabs at the end of January 2021, some staff members decided to leave, because they were against mandatory testing / vaccination.

What was the reaction of the patients? Have you noticed any new tendencies in their behaviour?

We have learned, that during the pandemics many psychiatric patients withdraw and isolate themselves. This led to interruptions in prescription medicine, not receiving consultations timely, even during the relapses. So, many patients were brought to us by emergency first medical help cars in severe deterioration of their mental health, and duration of their hospital treatment became longer.

Also, our psychologists dr. Ieva Vaskelienė and Ieva Salialionė have researched, whether during the pandemic to RVPH admitted patients experience increased suicide crisis rates, and which groups were affected the most. They have found that the number of suicide crisis increases in 30-39 and 80+ groups of men, who

Vilnius Republican Psychiatric Hospital

were diagnosed with disorders related to substance use (SUD) and organic mental disorders; also in a group of 70-79 years old women. However, there were not significantly increased suicide risk among all hospital patients during the pandemics period, compared with year 2019 before the pandemics. There were 1323 patients surviving suicide crisis assessed with psychosocial assessment form, age from 10 to 91 years (mean 37,61 years; 51,8 % men and 48,2 % women). In the sample of women, suicide crisis was found to be most common among 10–19 years of age, the frequency decreases steadily in the later age; in the sample of men, the frequency of suicide crisis increased from 10 to 19 years of age, reaches a peak in 30-39 years of age, and later it decreases. Suicide crisis are the rarest in 80+ years men. In the sample of women, suicide crisis were most common among patients with a primary diagnosis of schizophrenia spectrum disorder, while in a sample of men – personality disorder, frequently combined with SUD.

Most people complain about the changes because of the pandemia. But maybe there were some useful changes?

In December 2019 I had Professor Wolfgang Gaebel from Germany as the distinguished guest of Lithuanian Psychiatric association also visiting our hospital. Professor Gaebel has asked me, why having such a big hospital infrastructure scattered in the very old buildings (hospital was built in 1903, part of departments is already closed, and premises are conserved as historical heritage) among nice very old park, we don't have modern communication technologies among the staff and management, just phones (mobile or fixed landlines), without video chats. This was just some weeks before pandemics broke out. And in April 2020 we already installed computer-based communications not only within the hospital, but also with outside healthcare organisations, coordinating admissions and providing consultations for both patients and healthcare workers.

So, distance communication tools and skills have been developed very rapidly in the course of 2020.

Another very positive element is elevated standards of hygiene both by the staff and the patients. Yes, washing hands and sanitizing them with disinfectants, was not the strongest skill of our staff, and especially among our patients. Previously having sneezing nose or coughing while going to work to hospital was absolute normal. Pandemics made us aware about potential viral infections and damaging consequences of spreading it, especially among vulnerable or immunosuppressed populations, as many psychiatric patients are.

As I told before, we have learned, that during the pandemics many psychiatric patients withdraw and isolate themselves. This leads that they will not be vaccinated unless we will provide them vaccine against COVID-19 during the hospital admission. So, during the end of year 2020 and 2021 we have vaccinated about 200 patients, while they were treated due to relapse of mental disorder. This was never happening in Lithuania before, that patients have been vaccinated during their hospital admission. ■


MERRY
CHRISTMAS
AND HAPPY NEW YEAR

Transformation of psychiatric specialist training in Finland

Erkki Isometsä

Erkki Isometsä
MD, PhD, is a Professor of Psychiatry and Chief Physician at the University of Helsinki and Helsinki University Hospital. He is also President of The Finnish Psychiatric Association in 2020-2021, and has been an active researcher of mood disorders and suicidal behavior throughout his career.

Medical specialist training is undergoing a significant transformation in Finland, and this has and will have a profound impact in psychiatry. Not so long ago a licensed medical doctor simply registered into a medical faculty, and starting training was a matter of an announcement. In fields of medicine with abundant numbers of trainees, the real trial was only later in getting a post at a university clinic. However, this is now past after the new act on medical specialist training on medical and dental specialist training in force since 2020.

Compentency-based training and national coordination

In the current system, every applicant to the training is interviewed, and acceptance to the training programme is based on sum of scores from the interviews, clinical services and scientific merits. Interviews of applicants focus on areas that are significant in evaluating the applicants' aptitude to the specialty. Therefore, the interviews cover motivation, past work experience; interactional skills and cooperativeness in multidisciplinary teams; knowledge of substance of the field, and stress tolerance. This first acceptance is only provisional, and final acceptance is granted only after successful performance during a six-month trial period. The new act has also reduced the minimum duration of training from six to five years. However, the programme is competency-based, so duration depends on achieving the learning objectives, i.e. skills rather than calendar months.

During the earlier era, medical faculties of universities had autonomy in deciding the curriculum of their own specialist training, even if these were regularly discussed, negotiated and coordinated because of the national specialist exam. In the new era, the curriculum and guidance are national, and regulations similar between the universities. All universities still have their own scientific and clinical seminars and teaching, but the core curriculum and competency-based

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learning objectives are nationally the same. They are largely organized according to the principles of the CanMeds model; roles of medical experts as communicators, collaborators, leaders, health advocates, scholars, and professionals.

Specialist training in psychiatry has of course been developed already before the new regulations. Psychiatric departments have intensified their efforts in providing comprehensive theoretical and scientific education, content of which has been explicated in the core curriculum. Typically, this education has meant at least 2-5 weekly hours of theoretical education.

From a trainee's perspective, the most important developments have included mandatory weekly supervision and increasing emphasis on assessment and feedback on performance. A forthcoming element will be application of entrustable professional activities (EPAs) in training. These will be applied across medical specialties, and involve evaluation of trainee's performance in central tasks, in psychiatry such as structured diagnostic interviews formulating treatment plans. In important development is recruitment of senior experts into roles of part-time (20%) local coordinating educators, who will facilitate training by supervising, mentoring, evaluating following professional development of trainees.

Quo vadis?

Psychiatric training in Finland has overall improved a lot during the last few decades. The scope and aims of the training are increasingly more explicit, and the approach more systematic. Nevertheless, improving training is always work in progress. A hot potato is the extent of psychotherapy training, as there are questions pertaining both the resources of the medical faculties as well as the precise role of psychotherapy in future psychiatrists' workload. Nor are the skills of pharmacotherapy or neuromodulatory treatments sharpened as much as needed, and that is true for many other aspects as well. A major challenge for the few psychiatric educators is the expansion of psychiatric knowledge, and the breadth of scientific fields it entails, from molecular genetic to epidemiological. This will keep us busy ■

A Week in Psychiatry:

7 Days of Maris Taube

Ramunė Mazaliauskienė

Foreword by Ramunė Mazaliauskienė. **A Week in Psychiatry is an exciting topic when different people who work in the field of psychiatry share their experience. This time our guest is Maris Taube, president of the Latvian Psychiatric Association. Should say, the week is filled with psychiatry.**

Monday

My working day starts at 7:30. I go through nurses' reports - what's happened during the holiday in my department for patients with depression, anxiety, early-stage schizophrenia, eating disorders, early dementias. Everything seems good, some sleep problems, some panic attacks. The phone starts ringing without any pauses. My patients knows that I am in the office. Questions about medicines, some symptoms changes, next visits, COVID situation, vaccination necessary, risks etc. I try to also complete my delayed paper works.

9:00 morning coffee with my colleagues, short discussion about planning of new patients for today.

From 9:30 till 12:30 we all together (me, my colleagues, residents) visit all patients in my department. We speak with each of all up to 30 patients in department, discuss treatment results, progress, medicines, psychosocial treatment methods.

From 12:30 till 13:00 we have lunch together with colleagues, tell some jokes and funny stories.

From 13:00 till 14:00 I make a lot of phone calls; I call new patients and invite them to my department (unfortunately waiting time is about one months).

From 14:00 till 18:30 I go to the outpatient's clinic and provide consultations for about 15 to 20 patients, do a lot of paper works.

18:30 I go home.

Maris Taube
has been working for 20 years in public health, public mental health, health economics and health care areas. He has served for ten years as National counterpart at the WHO European Region Mental health program, for six years as Member of Board at European Monitoring Centre for Drugs and Drugs Addiction and Member of the European Commission Committee of Alcohol Policy and Action. He has been director of National Health Service for three years (2012-2014) and was responsible for the health care financing system in Latvia. He is a professor (community and social psychiatry) at Riga Stradinš University Department of Psychiatry and Narcology, takes part in different projects (Co-chair of the NATO Science and Technology Organization Panel of Human Factors and Medicine Research Task Groups (HFM-RTG 218 "Military Suicide" and HFM-RTG 277 "Military Leadership"), members of the COST project IS 1302 "Towards an EU research framework on forensic psychiatric care" and other projects. He is a chief of the Community Mental Health clinic with in-patient department for depression, anxiety "Veldre" of the Riga Centre of Psychiatry and Narcology, he also works as psychiatrist in outpatient and in-patient departments, he is a-President of Latvian Psychiatrist Association.

Tuesday

My working day starts at 7:30. It's time for patients' phone call, phone consultations.

From 8:30 till 9:00 we provide team meeting all together – psychiatrists, residents, psychologists, visual art therapist, music therapist, drama therapist, dance, and movement therapist, ergo (occupational) therapist, physiotherapist. Shortly we have a conversation about patients, exchange our impressions about progress, issues.

9:00 Morning coffee.

After that every psychiatrist, residents visits their own patients, discussion with residents about treatment, some administrative issues, paper works. Zoom meetings about hospital problems, COVID 19 epidemiological, safety issues, new rules from Ministry of Health (again...), admission of new patients, individual discussion with patients in my office, meetings with patients' relatives. At the end of the day, I provide 3 to 4 outpatients face to face, phone of WhatsApp consultations.

18:30 I go home.

Wednesday

My working day starts at 7:30. Phone calls, consultations, advises.

9:00 morning coffee with my colleagues, short discussion about planning of new patients for today.

From 9:30 till 12:30 we all together (me, my colleagues, residents) go to common patients' observation. We speak with each of all up to 30 department inpatients, discuss treatment results, progress, medicines etc.

From 12:30 till 13:00 we take lunch together with colleagues, some jokes and funny stories.

From 13:00 till 14:00 I make a lot of phone calls; I call to new patients and invite it to department.

From 14:00 till 18:30 I went to outpatient's clinic and make consultations for about 15 to 20 patients, do a lot of paper works.

18:30 I go home.

Thursday

My working day starts at 7:30. It's time for patients' phone calls, phone consultations.

9:00 Morning coffee.

After coffee usually almost every Thursday I go to main hospital facility and take part in Concilium's for a person who will change the gender, for patients with some legal problems (e.g., request for an evaluation of mental status from military services, legal institutions, state security services etc.).

At the same time every psychiatrist, residents visit their own patients, discussion with residents about treatment, some administrative issues, paper works. Admission of new patients.

After that I provide 3 to 4 outpatients face to face, and have WhatsApp consultations at end of the day.

18:30 I go home.

Friday

My working day starts at 7:30. Phone calls, consultations, advises.

9:00 morning coffee with my colleagues, short discussion about the planning of new patients for today. Some jokes, but not so much.

From 9:30 till 12:30 we all together (me, my colleagues, residents) do common patients observation. We speak with each of all up to 30 department inpatients, discuss treatment results, progress, medicines. Friday we also correct and prepare treatment plans for next week – we write down all necessary treatment activities (music, art, drama etc.) for each patient, ask them to provide feedback – what was useful, what was not. We also make plans for discharge, start to prepare patients for that I timely manner.

From 12:30 till 13:00 we have lunch together with colleagues, some jokes and funny stories, but seem not so funny. Everyone is tired.

Usually, 3 to 4 patients discharge on Friday. Also, some patients are admitted or transferred from main hospital acute departments. A lot of paper and computer work.

18:30 I go home.

Saturday

Some paper works at home. I went through e-mails, planning some Latvian Psychiatric Association meetings, prepared letters and/or working papers for Ministry of Health and others, wrote scientific papers for the University, prepared presentations for conferences. Some work in the garden.

I am getting tired.

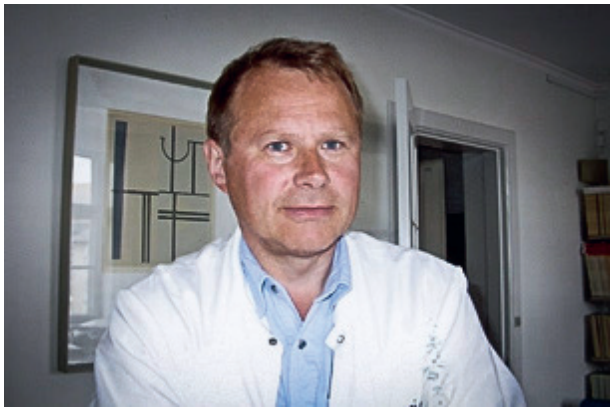
20:30 Sauna, jacuzzi.

Sunday

I am good. I am ready for work again!

Highlights from the Nordic Journal of Psychiatry

Martin Balslev Jørgensen



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

Long acting injectable antipsychotics for bipolar disorder

This study aimed to determine whether the addition of a long-acting injectable antipsychotic (LAI-AP) has a positive effect on prognosis in bipolar disorder. Medical records of patients with bipolar disorder who were using LAI-AP at least for one year in the community mental health center (CMHC) until March 2020 were investigated. Comparisons were made between the period of one year before and after the initiation of LAI-AP. There were 197 patients with bipolar disorder who were attending to the CMHC and 17 of them were under maintenance treatment with LAI-AP for at least one year. The LAI-APs used were aripiprazole (n = 8), paliperidone (n = 5) and risperidone (n = 4). During the one-year period after the LAI-AP initiation, there were fewer days spent in hospital and the number of hospitalizations was lower than the year before the LAI-AP use. The authors **conclude** that LAI-AP use may have positive effect on course for selected patients with a long history of bipolar disorder.

Yıldızhan E, Uzun E, Tomruk NB. Effect of long acting injectable antipsychotics on course and hospitalizations in bipolar disorder - a naturalistic mirror image study. *Nord J Psychiatry. 2021 Jun 14:1-7. doi: 10.1080/08039488.2021.1931714. Online ahead of print. PMID: 34124986*

Is aberrant salience a predisposing factor for psychosis?

Aberrant salience (AS) is conceptualized as a potential predisposing factor for psychotic states of mind. The authors aim of this cross-sectional study is to evaluate the AS subjective experience in Ultra-High Risk (UHR) adolescents and young adults compared to help-seeking peers with First Episode Psychosis (FEP) and (2) to assess any significant association of baseline AS with psychopathology and functioning in UHR participants. Participants aged 13-35 years, completed the Comprehensive Assessment of At-Risk Mental States (CAARMS), the Aberrant Salience Inventory (ASI) and the brief version of the Schizotypal Personality Questionnaire (SPQ-B). No difference in baseline AS subjective levels was found between UHR and FEP participants. In UHR individuals, the ASI total score was significantly associated with attenuated positive symptoms, depression and specific schizotypal personality traits. The authors **conclude** that AS is clinically relevant in UHR subjects, comparable to FEP patients. Moreover, it seems to mutually interact with schizotypy in the clinical manifestation of attenuated positive psychopathology

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Stability of personality traits in psychotic patients

Personality is an aspect that can affect the symptoms and social function in individuals with psychotic disorders. No study has examined the stability of personality traits exceeding five years in patients with schizophrenia and related disorders. The aim of this study was to investigate the stability of personality traits over a 13-year period among patients with schizophrenia and related disorders and healthy individuals and to evaluate case-control differences. At three occasions during 13-year period patients with schizophrenia and related disorders (n = 28) and healthy individuals (n = 57) completed Swedish universities Scales of Personality (SSP). It was found that tests of within-subject correlations showed differences in two subscales: Lack of Assertiveness, which were influenced by age, and Physical Trait Aggression, where patients' ratings were stable, whereas controls rated themselves less aggressive at a higher age. Between-subjects correlations showed differences regarding diagnosis, time, age, gender, or age × gender in nine of the 13 subscales as well as in factor Neuroticism. The authors **conclude** that long-term follow-up showed generally high stability of personality traits measured with SSP. Between-subject analyses over the 13 years showed that patients differed compared to controls for the SSP factor Neuroticism as well as the subscale Detachment.

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Does unipolar mania imply a distinct neurocognitive profile?

Despite a growing number of studies reporting patients with a history of mania without depression have several socio-demographic and clinical differences than bipolar disorder patients, unipolar mania is recognized as bipolar I disorder in the most commonly used classification systems. The aim of this study is to evaluate the neurocognitive differences between unipolar mania, bipolar I disorder and healthy controls, and to reveal the underlying neurocognitive differences. Cambridge Neuropsychological Test Automated Battery was applied to 18 unipolar mania, 19 bipolar I disorder patients and 21 healthy controls matched for age, sex and education levels. Unipolar mania group had worse performance regarding visual memory and executive functions and had specific social cognition deficits compared to both bipolar I disorder and healthy control groups. The authors **conclude** that the study indicates that unipolar mania might have unique neurocognitive differences compared to bipolar I disorder, which might support the hypothesis that unipolar mania is a distinct neurocognitive disorder within bipolar spectrum disorders.

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