



World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

Editorial Column

Dear Colleagues,

Welcome to the latest issue of "World Child and Adolescent Psychiatry," the official journal of the World Psychiatric Association, Child and Adolescent Psychiatry section (WPA CAP).

First I would like to thank representatives from all around the World, who re-elected Prof. Bennett Leventhal (USA), Dr. Gordana Milavic (UK) and me to lead the WPA CAP section for another three years. The elections were held at the WPA tri-annual congress in Madrid, Spain. The support and the trust expressed by the delegates give us strength to continue our work for child and adolescent psychiatry in the World.

As a secretary general of the section I am getting, more than ever before, requests (via the WPA office in Geneva, Switzerland and also directly) to join the WPA CAP section. The spectrum of applicants is extremely broad, from medical students to internationally renowned professors and presidents of national societies. At the recent WPA tri-annual congress in Madrid I was told that some WPA sections are functioning like exclusive societies, with some even charging a membership fee. We encourage everyone who is passionate about child and adolescent psychiatry to apply for membership with WPA CAP: we have no membership fees, and we provide support (often from a distance) to associations and individual child and adolescent psychiatrists around the globe. We aim to improve the lives of children and adolescents with mental disorders around the world, by working together with our members to improve the quality of care and by promoting mental health through the organized efforts and informed choices of society.

Through being inclusive, proactive, nurturing, and collaborative, we have secured unprecedented growth in our section over the past three years. This issue of World CAP, and in particular, Prof. B. Leventhal's editorial, highlight where our section will be heading in the next three years. Prof. Leventhal challenges all of us personally to ponder this question... "What are your plans for global child mental health?" We are all busy doctors, but there are always opportunities to work on global agendas. We know many of you are working hard on them.

Our newly reelected Chair Prof. Bennett Leventhal kindly asked me to continue to serve as the Editor of "World Child and adolescent Psychiatry" for another three years. I have accepted this offer with pleasure as I am delighted to continue to work with my deputy editors Prof. Anthony P. S. Guerrero (USA), Dr. Jibril Abdulmalik (Nigeria) and Dr. Tomoya Hirota (Japan/USA) and the members of Editorial Board (listed at the last page of this journal).

Happy readings!

Professor Norbert Skokauskas (Norway)
Editor, "World Child and Adolescent Psychiatry"
Secretary, World Psychiatric Association, Child and Adolescent Psychiatry Section
<http://www.wpanet.org/> N_Skokauskas@yahoo.com





World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

Prof. Bennett L. Leventhal (USA)

Chair's Column:

*"All the world's a stage,
And all the men and women merely players;
They have their exits and their entrances,
And one man in his time plays many parts,"
As You Like It Act 2, scene 7, 139–143*

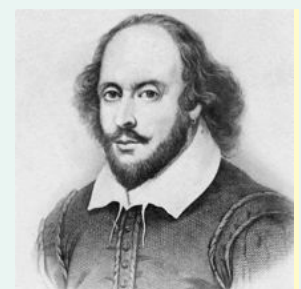


From our school days, many of us remember reading Shakespeare and trying to decipher his sweet but complex text. The past few months have seen Child and Adolescent Psychiatry on the world stage, most recently in New York (APA), Madrid (WPA), Durban (IACAPAP) and San Diego (AACAP). And, many of us have been players in complex training, scientific and political processes. Each of these roles is important, as they represent opportunities to showcase our knowledge and expertise as well as to advocate for the needs of our patients and families. This is all well and good. We should even be proud of our efforts. However, have we made the clearest and strongest case for who we are, what we do and how we play a special role in the psychiatry, medicine and the care of children?

What many of us may not know, or even remember, is that Shakespeare has something in common with us. He was not only interested in but may have been a bit of an expert in development. In fact, if one were to return to the same scene in *As You Like It*, you will note the following:

*"His acts being seven ages. At first, the infant,
Mewling and puking in the nurse's arms.
Then the whining schoolboy, with his satchel
And shining morning face, creeping like snail
Unwillingly to school. And then the lover,
Sighing like furnace, with a woeful ballad
Made to his mistress' eyebrow. Then a soldier,
Full of strange oaths and bearded like the pard,
Jealous in honor, sudden and quick in quarrel,
Seeking the bubble reputation
Even in the cannon's mouth. And then the justice,
In fair round belly with good capon lined,
With eyes severe and beard of formal cut,
Full of wise saws and modern instances;
And so he plays his part. The sixth age shifts
Into the lean and slippered pantaloons,
With spectacles on nose and pouch on side;
His youthful hose, well saved, a world too wide
For his shrunk shank, and his big manly voice,
Turning again toward childish treble, pipes
And whistles in his sound. Last scene of all,
That ends this strange eventful history,
Is second childishness and mere oblivion,
Sans teeth, sans eyes, sans taste, sans everything."*

As You Like It Act 2, scene 7, 144-166



William Shakespeare
(1564 - 1616)



World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

Prof. Bennett L. Leventhal

Chair's Column (cont.1):

If a 16th Century poet like Shakespeare can clearly articulate his developmental perspective, how well are we doing? Well, as has been said, I have good news and bad news. Because I am largely an optimist, I will start with the good news.

First and foremost, at international meetings, there is a strong and growing presence of Child and Adolescent Psychiatry. We have been increasingly presenting our work and methods on the international stage and demonstrating our special developmental, biomedical perspective for general psychiatrists, physicians in other disciplines and professionals from a myriad of professions interested in Child and Adolescent Psychiatry. This is wonderful. At the APA meeting in New York, there was a large cadre of our colleagues from around the world presenting, learning about, and discussing developmental psychopathology and its treatment.

The WPA meeting in Madrid was particularly exciting, especially for WPA CAP. First and foremost, we had a very strong presence in the scientific program. There were many sessions covering a multitude of topics. And, unlike the previous WPA meeting in Buenos Aires, where we were assigned to the smallest and most out-of-the way rooms, we were assigned to large, centrally-located meeting rooms where we drew very large audiences. This was exciting and gratifying, especially when senior WPA officials peered into our meeting rooms to find them filled with enthusiastic audiences.

Political events at the WPA meeting were also important for Child and Adolescent Psychiatry. First of all, Professor Dinesh Bhugra became the WPA President and, as part of his Presidential plan, he has included significant effort in Child and Adolescent Psychiatry... more on that later. At the same meeting, WPA officials recognized the important growing level of activity in the WPA CAP Section. The multifaceted activities of our members and our journal, World Child and Adolescent Psychiatry, made it clear that we are one of the most active WPA sections and a growing force in the WPA. Our Secretary and Journal Editor, Prof. Norbert Skokauskas was selected to be amongst a small group of officials led by Prof. Felice Lieh-Mak (Hong Kong), WPA president (1993 - 1996) to supervise a tightly contested election in which Australian Psychiatrist, Helen Herman, was declared WPA President-Elect. The group was This, too, is important to us, as Dr. Herman is Professor of Psychiatry at the University of Melbourne, whose career has focused on the mental health of youth and women, in part through her appointment in the Academic Centre for Youth Mental Health. Professor Herman has already expressed a keen interest in meeting and working with our section during her presidency.

Also in Madrid, WPA CAP section officers attend the Assembly meeting as well as other meetings that not only offered visibility but also chances to develop new networks for working on the international stage. During the meeting, CAP Section had its meeting, which took place in the middle of the congress but was still attended by more than 30 colleagues from every continent. We reviewed the activities of the section for the past triennium and considered plans for interacting more effectively with the WPA and colleagues in other organizations. The current officers were gratified to be re-elected for a second and final term.

In October, there were 4,000 attendees – 25% from outside the US – at the AACAP meeting in San Diego. WPA CAP was pleased to join with our colleagues in the AACAP and the IACAPAP as part of Professor Paramjit Joshi's AACAP Presidential Initiative. Clearly, efforts to work together to expand



World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

Prof. Bennett L. Leventhal
Chair's Column (cont.2):

international networks and standards has begun. And, while we have a long and complex path ahead, this important journey has begun. As in Madrid, the WPA CAP Section held a meeting in San Diego. We were honored to have WPA President Dinesh Bhugra attend the meeting and talk about his initiatives, especially with respect to Child and Adolescent Psychiatry. This included a clear invitation to join him in changing the plight of children facing adversity and childhood psychopathology. This was followed by a formal invitation for WPA CAP to join the Bhugra Presidential Action Plan.

In San Diego, we took another important step forward in a meeting between IACAPAP and WPA CAP. At that time, we shared perspectives and agreed to seek out common agendas so that we can work more effectively together. While no conclusions were reached, there was a clear agreement to continue discussions with the hope of uniting our efforts into a more formidable force on the international scene.

So, with all this good news, what is the bad news? Well, sadly, there is a lot. In recent reports to the WPA CAP Assembly, our colleagues from each section of the world expressed serious concerns about the desperate shortage of Child and Adolescent Psychiatrists. And, even when Child and Adolescent Psychiatrists are present, there are not enough resources to provide care for more than a small portion of children in need. This shortage is only punctuated by the tragedies associated with disasters, war, and events like the Ebola epidemic in Africa. Children still clearly bear the brunt of the pain associated with these catastrophes, and we are still ill-equipped to provide services and support. Even more evident is the lack of developmentally appropriate care and treatment from properly trained professionals who have those unique skills that are necessary to care for children and youth. Why do we keep hearing this story again and again?

Equally disturbing is the failure of many countries to even recognize Child and Adolescent Psychiatry as a legitimate medical discipline. This fact has a huge impact on funding for training, research and treatment. In short, in many countries, we are failing to convey the message about our very special discipline of medicine and the crucial role we play in understanding the complexities of human brain development and how its perturbations lead to illness and disability for a lifetime. This is our bad news: bad news that we must acknowledge.

With each passing month, it is clearer and clearer that there is a pressing need for us to make it clear to our colleagues and policy makers that Child and Adolescent Psychiatry is a real and necessary medical discipline. We must articulate our role as developmentalists who have a unique appreciation for the development of the brain and its crucial developmentally influenced functions related to cognition, behavior and emotions in health and disease. We must make it clearer and clearer why and where we are needed – in our offices, in hospitals, in primary care offices, in schools and throughout communities in need. Our visibility at meetings in New York, Durban, Madrid and San Diego are good starts but not quite good enough. Now it is your turn to stand up and be counted in your communities and your nations. And, we know you cannot do it alone. So, together with our colleagues at WPA, AACAP and IACAPAP, WPA CAP will help organize activities and messages so that our story is more and more clearly told and so that we can accomplish our ultimate goal, which is to provide Child and Adolescent Psychiatry – developmentally-based services in the areas of prevention, diagnosis and treatment – for children and youth all over the world.



World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

WPA President Prof. Dinesh Bhugra attends AACAP annual meeting and joins WPA Child and Adolescent Psychiatry Section representatives assembly at AACAP

WPA CAP Editors

AACAP stands for American Academy of Child and Adolescent Psychiatry. The mission of AACAP is to promote the healthy development of children, adolescents, and families through research, training, prevention, comprehensive diagnosis and treatment and to meet the professional needs of child and adolescent psychiatrists throughout their careers. AACAP focuses on providing child and adolescent psychiatrists the resources they need in order to promote mentally healthy children, adolescents, and families.

AACAP's (American Academy of Child and Adolescent Psychiatry) Annual Meeting is the largest gathering of child and adolescent psychiatrists in the world. Held in October each year, the Annual Meeting features the latest in research and clinical practice in the field with hundreds of programs given by top speakers. This year's AACAP meeting for a very first time was attended by the WPA leadership. President Dinesh Bhugra gave Noshpitz Cline History Lecture: The Future of Mental Health Services in the 21st Century. Below is the summary Bhugra's lecture.

It is clear that mental health is an integral part of an individual's well-being and has to be seen as such. Data from the United Kingdom (UK) show that economic burden related to poor mental health in the UK is significant – higher than cardiovascular diseases and cancer. Globalization, economic downturn, policy changes, and aging population all are significant factors affecting services. Dr. Bhugra presented an enquiry report from the Mental Health Foundation in the UK about the future of Mental Health Services. Topics included: integration between physical and mental health and social care and between primary care and secondary care; school-based programs; greater personalization of services and the engagement of patients and their care takers and families as equal partners in decisions about care; future changes needed in training; and coordination of transitions across age groups. A need for mental health to be treated as a core public health issue, so that it will be as normal for everyone to look after their mental health as it is to look after their physical health and a public health workforce that sees mental health as one of its core responsibilities. This has major implications for child and adolescent psychiatry.

Dr. Dinesh Bhugra also highlighted that in the near future he will be attending H20 meeting which follows G20 meeting and Davos forum in Switzerland with a clear plan to put mental health on a large global agenda.





World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

Global Perspectives on Teaching and Learning About Child and Adolescent Psychiatry

Dr. Tomoya Hirota (Assistant Editor, USA)

Dr. Say How Ong (Singapore)

Dr. Flavio Silva (Brazil)

Dr. Ian Munt (Australia)

At AACAP's 61st annual meeting, held in October 2014 in San Diego, USA, Professor Skokauskas (Norway) organized a three-hour session that consisted of four oral presentations that featured postgraduate child and adolescent psychiatry training in several countries and regions, as outlined below. This session provided a global perspective on postgraduate child and adolescent psychiatry training with a focus on current challenges, choices and solutions.

First, Dr. Ong discussed dramatic changes in medical education in Singapore following the implementation of the Accreditation Council for Graduate Medical Education–International (ACGME-I) accreditation system and the National Psychiatry Residency Program in 2010. With these newly developed systems, trainees undergo a five-year comprehensive program in which they work in variety of mental health settings. They have a three-month experience in child and adolescent psychiatry (CAP) during their third year of residency and have fifth year elective time in which they can obtain advanced training in CAP.

Next, Dr. Silva reported on the current status of child and adolescent mental health in Brazil. Dr. Silva reviewed articles on the epidemiology of youth mental illness in Brazil and highlighted the unmet needs notwithstanding the 1988 Brazilian Constitution that gave rise to the Unified Health System (SUS), which intended to guarantee free and universal healthcare access for the entire population. In addition to the overall scarcity of child and adolescent psychiatrists and allied professionals, there are geographical inequalities in the distribution of these professionals, with only one certified specialist for 16 million people in the Northern region.

Next, Dr. Munt from Australia reviewed the Royal Australian and New Zealand College of Psychiatry's structure and described the prerequisites for CAP subspecialty training. He discussed the competency-based training model, emphasizing workplace-based assessments, learning objectives, and professional activities.

Next, this writer summarized the findings of an international survey on CAP postgraduate training in the Far East. This survey investigated CAP needs and current training programs to benefit future workforce development in this young, rapidly growing world region, where little is currently known about CAP needs and workforce supply. The informants for this project were from the Consortium on Academic Child and Adolescent Psychiatry in the Far East (CACAP FE), which was established in 2011 with the World Psychiatry Association, Section on Child and Adolescent Psychiatry, Group on Teaching and Learning.



World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

(cont.1)

Following these presentations, AACAP president Dr. Joshi provided a highly insightful and inspiring discussion on the current U.S. postgraduate training system, including the triple-board program (i.e. combined residency in pediatrics, general psychiatry, and child and adolescent psychiatry). The audience, which included other internationally renowned child and adolescent psychiatrists, provided several constructive comments and feedback points that stimulated further thought and discussion. Overall, the session was successful in describing the current global status of CAP training as well as the real-world unmet needs for youth mental health, and in discussing next steps for further advancement of our specialty.





World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

Madrid 2014

SAFEGUARDING CHILDREN AND ADOLESCENTS: THE WPA CAP STRATEGY

Dr. Gordana Milavić (UK)
Co Chair
WPA Child and Adolescent Psychiatry Section



At the September 2014 XVI World Congress of Psychiatry in Madrid, WPA President Professor Dinesh Bhugra outlined his plans for his coming presidential term. One of the strategic 'pillars' of his work plan includes the well-being of children and adolescents and the importance of protecting children and adolescents from abuse. I had great pleasure in accepting Professor Bhugra's invitation to join him during his plenary address and had the opportunity to set out the WPA Child and Adolescent Section's plans for tackling child abuse.

The story of Victoria Climbié in 2000 caught media attention and set into motion a range of safeguarding legislation in the United Kingdom aimed at protecting children. Victoria was born in Adobo, Côte d'Ivoire and accompanied her great-aunt Marie-Thérèse Kouao, a French citizen, to receive education in France. The two arrived in London in April 1999. Soon after, Victoria and her aunt moved in with the aunt's boyfriend, and it is suspected that the abuse suffered by Victoria worsened from then on. Despite the involvement of the National Health Services, Social Servicers, the Police, the National Society for the Prevention of Cruelty for Children, and the local churches – who all noted that Victoria was being abused – not one of these agencies acted effectively in order to save Victoria's life. The severe physical injuries and chronic neglect meted to her by her abusive carers led to Victoria's tragic death a year after her arrival in the UK.

It is reported that, during the criminal trial, the judge referred to the 'blinding incompetence' of all agencies involved. A subsequent public enquiry, led by Lord Laming (2003), issued detailed recommendations for the protection of children in England. Victoria's death led to a series of child protection legislative and practice documents.

However, over the past decade and a half and in current everyday practice one continues to hear about child maltreatment and omissions in the protection of children. The problem remains both in the developed world, where awareness is supposedly high, and in countries where child abuse has not even begun to be addressed. Thus, the WPA President has made prevention of child abuse one of his main priorities.

What is maltreatment? Are the physical abuse of children and intimate partner violence normative behaviours? It is said that identifying child abuse in multicultural societies is complex. Does this mean that we should not interfere with abusive practices? The answer is a categorical "no." The definition of abuse is simple: it is a failure to meet the child's developmental needs: a universal right of every child. The consequences of maltreatment include death; delays in a child's physical, cognitive, emotional and social development; eventual conduct disorder, emotional disorders, delinquency and criminal behaviour, risk-taking behaviours, addiction, and suicide; adult physical and mental health problems; reduced employment opportunity; social exclusion; intimate partner violence and trans generational influences on abusive parenting. Protecting children is a global problem, and it should accordingly encompass initiatives to



World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

(Cont. 1)

prevent and stop any abuse whatever the social and cultural context may be. The response to and prevention of child abuse are moral and economic priorities.

In a UK community study, as many as one in five children experienced some form of abuse (Radford et al., 2011). The different forms of child abuse include neglect and emotional, physical and sexual abuse. The prevalence of physical abuse ranges from four to 16 percent of children in high-income countries. It is estimated that ten percent are neglected or emotionally abused and at least 15 percent are exposed to some form of sexual abuse (Gilbert et al, 2009).

Research and clinical practice point to well known risk factors, including: parental mental health problems, particularly maternal depression, psychotic disorders, substance and alcohol abuse, and learning disabilities; adverse family circumstances including domestic violence; social isolation and lack of family support; and socio-political factors.

An addition to this list of different forms of child abuse is Female Genital Mutilation (FGM), a form of child abuse with devastating physical and psychological consequences for girls and women. The World Health Organization describes it as: "procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons (WHO, 2013)." In the UK, performing FGM and assisting a girl to perform FGM on herself have been classified as serious criminal offences under the Prohibition of Female Circumcision Act (FGMA) since 1985. In 2003, the FGMA tightened this law, resulting in prosecution for FGM being carried out on overseas UK citizens. Anyone found guilty of FGM faces a maximum penalty of 14 years in prison (NSPCC Factsheet, 2014).

Where should one start when considering prevention of child abuse? The 1989 the United Nations Convention on the Rights of the Child states that the best interest of the child is paramount. Children have rights of protection, including the right to be protected from any form of maltreatment or exploitation that threatens their survival, development, or wellbeing. Effective prevention should be a primary focus.

The UK Green Paper, Every Child Matters (2003), refers to the entitlements of every child to be healthy, to stay safe, to enjoy and achieve, to make a positive contribution, and to achieve economic wellbeing. The WPA and the WPA Child & Adolescent Psychiatry (CAP) Section adhere to the principles of the UN Convention on the rights of children and endorse the specific legislative frameworks – where they exist – aimed at safeguarding children. The CAP Section hopes to raise awareness of child maltreatment through: educational and training events; advocacy work with statutory, voluntary, and policy making bodies to establish early intervention and prevention programmes; assistance with the development of statutory social work and voluntary agency plans and policies on safeguarding; dissemination of existing child legislation; and involvement – wherever locally possible – of primary mental health, social services, educational, law enforcement, and legislative bodies, in order to ensure good interagency collaboration and communication. Training at undergraduate and postgraduate levels is essential. Most importantly, it seems that the lessons learnt from countries where child safeguarding has gained legal and practice prominence must be shared so that pitfalls and mistakes can be avoided and successful policy making and practice can be shared.



World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

Radio show “About Our Kids” – from New York to all over the world

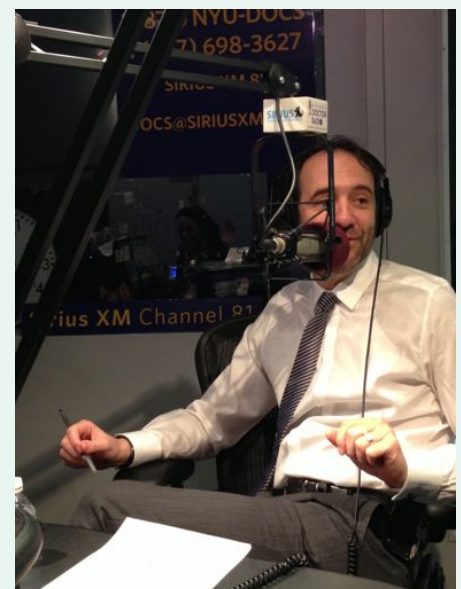
Dr. Tomoya Hirota (Assistant Editor, USA)

We are very thrilled to introduce Dr. Jess Shatkin. Dr. Shatkin is a New York based child and adolescent psychiatrist, and he runs a unique radio program focusing on child and adolescent mental health.

Dr. Shatkin is the Vice Chair for Education at the New York University (NYU) Child Study Center, where he is an active clinician, teacher, administrator, writer, and investigator. He is also the creator and director of the largest undergraduate child and adolescent psychology program in the country. Dr. Shatkin has published primarily in the areas of child mental health policy, complementary and alternative medicine, sleep medicine, and medical education. He has just completed the second edition of his book, “Treating Child and Adolescent Mental Illness: A Practical All-in-One Guide,” first published by W.W. Norton in 2009, and now retitled, “Child and Adolescent Mental Health: A Practical All-in-One Guide.” The book will be published in spring of 2015.

With regard to his radio show, NYU medical center launched a relationship with Sirius XM Satellite Radio and started the Dr. Radio channel in February of 2008. The show is called About Our Kids (<http://www.aboutourkids.org/sirius>) and brings on guests each week to discuss all aspects of children's mental illness. His show covers many specific conditions, including ADHD, autism spectrum disorder, and depression. He also discusses other topics of interest to families and parents, including divorce, spirituality, children's media, parenting & discipline, sleep, and children's public mental health. The show is broadcast live on Fridays from 8 – 10 AM Eastern Standard Time and replayed throughout the week. On each show, Dr. Shatkin typically interviews a few guests, who speak amongst themselves. He and takes calls from across the nation, from Canada, and from American Service personnel working in Europe. The show is both a great deal of fun and a significant public service. It provides a good opportunity for guests to recruit patients for studies and to promote the value of their work. The show is co-hosted with two other insightful psychologists at NYU: Drs. Lori Evans and Alex Barzvi. Further details on Dr. Shatkin's show can be found on the Child Study Center's website: [Aboutourkids.org](http://www.aboutourkids.org). The specific link for his show is: <http://www.aboutourkids.org/sirius>.

This radio show is the first and only one nationally that covers child and adolescent psychiatric topics. Most importantly, this show is accessible to the public with subscription fee (around , including people outside of the U.S. via the website <http://www.aboutourkids.org/sirius.rn> on the radio (or go to the website above) and stay tuned for upcoming shows!





World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

WPA CAP at Mental Health Training in Pune, India 28th September to 1st October 2014

Dr. Gordana Milavić (UK)
Co Chair
WPA Child and Adolescent Psychiatry Section

A delightful audience of more than 100 primary mental health workers and graduate psychologists filled the auditorium day after day during a four day training course held in Pune, India.

Four consultant psychiatrists from the UK, Dr. Cosmo Hallstrom, Dr. Ghazala Afzal, Dr. Shirine Pezeshgi and Dr. Gordana Milavić, delivered a modified training curriculum along WHO mhGAP lines, covering basic principles of assessment and treatment of common mental health problems encountered in daily practice. This was also an opportunity to acquaint those attending with research trends and clinical practice in the UK.

The training course was jointly organised by the UK based charity Concern for Mental Health; the Indian based Makhul Madhav Foundation; and the World Psychiatric Association, Child and Adolescent Psychiatry Section.

The most striking aspects of the training were the participants' enthusiasm, rich knowledge base, and excellent and sometimes challenging questions throughout the four days of training. It felt like a large workshop, with much experiential training, role play, and videos delivered alongside more didactic teaching. The mental health workers pointed to a lack of trained psychiatrists and absence of team work in many of their workplaces, although we also heard about some excellent examples of multidisciplinary practice involving mental health workers, psychiatrists, paediatricians, and voluntary agency staff. The meeting was truly a bidirectional learning experience for trainers and participants.





World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

Interview with Dr. Takahiro Kato

Takahiro A. Kato, M.D., Ph.D.
Associate Professor
Department of Neuropsychiatry
Graduate School of Medical Sciences
Kyushu University, Japan

Dr. Kato, thank you very much for agreeing to the interview. It is our pleasure and our privilege to have you as part of this issue of the WPA CAP journal. Could you tell us a bit about yourself and the important research you have done and what you are working on in the mental health field?

I graduated from and obtained my medical degree from Kyushu University School of Medicine (Fukuoka, Japan) in 2000. At that time, the current two-year mandatory postgraduate training program - in which medical school graduates are required to complete two years of training in internal medicine, surgery, emergency medicine, anesthesiology, pediatrics, obstetrics/gynecology, and psychiatry prior to specialty training - had not yet commenced, and thus I started psychiatric specialty training shortly following medical school graduation. Psychiatric training involved a "learning from experiences" format, and thus I was able to gain a broad perspective seeing many cases in acute psychiatric wards and outpatient clinics of private psychiatric hospitals. During such experiences, my interest in group psychotherapy and psychodynamic psychotherapy developed. I returned to Kyushu University Hospital when Professor Shigenobu Kanba was appointed in 2004. In order to clarify a variety of questions I had embraced through my early clinical experiences, I entered the graduate school of Kyushu University, and in 2008 I attained a PhD for my research in psychoneuroimmunology.

During that time, as I continued my clinical work, I encountered and treated various socially withdrawn patients who were labeled hikikomori in Japan. One of them had Autism Spectrum Disorder (ASD) and was also the victim of domestic violence. He required psychiatric hospitalization for medical care and protection. Another one rejected communication from parents and others and subsequently withdrew from society. The first patient received pharmacotherapy and family therapy, and the second underwent psychoanalytical therapy. Over the past ten years I have continued to follow both patients, and my experiences with treating such patients have formed the starting point for my research into hikikomori.

Would you be able to explain more about the psychopathology of hikikomori in youth? Is it a culture-bound syndrome in Japan or is it a more pervasive phenomenon that we see outside of Japan as well?

The Hikikomori syndrome is defined as complete withdrawal from society for 6 months or longer. Dr. Tamaki Saito initially highlighted hikikomori among Japanese youth in the late 1990s, and hikikomori has been defined in the latest version of Oxford dictionary (2010, September) as " (in Japan) the abnormal avoidance of social contact, typically by adolescent males/a person who avoids social contact [Origins] Japanese, literally 'staying indoors, (social) withdrawal'." A recent population based survey indicated that at least 1 % of people in Japan had experienced hikikomori in their lifetime. While the pathology and causes of hikikomori have yet to be clarified, traditionally, it has been suggested that the syndrome is caused by the unique Japanese cultural background and socio-cultural changes in Japan. The following are tr



World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

(cont'd 1)

I. Japanese Sociocultural Characteristics

a) Amae-based Society

One of the original Japanese psychoanalysts, Dr. Takeo Doi, identified Amae as a unique form of dependent behavior in Japanese culture, and I suppose that Amae is one of the more influential factors contributing to a significant prevalence of hikikomori in Japan. The person who is acting Amae may beg or plead, or alternatively act selfishly and indulgently, while secure in the knowledge that the caregiver will forgive this behavior. The behavior of children towards their parents is the most typical example of Amae. Dr. Doi argued that child-rearing practices in Western society seek to stop this kind of dependence in children, whereas in Japan it persists into adulthood in all kinds of social relationships.

b) Shame-based Society

We Japanese refer to shame as Haji, which is very painful and enough for a person to escape or drop out of their own society. I hypothesize that Haji is one of the most influential cultural factors contributing to hikikomori as well as Taijin Kyofusho, which is another traditional culture-bound syndrome involving fear of interpersonal relations. Additionally, I believe that Haji is the key factor contributing to suicide among Japanese. As you know, Japan's suicide rate is extremely high compared to other developed countries.

c) Overprotectiveness, or Kahogo

Compared to parents in Western families, Japanese parents tend to overprotect their own children. This overprotection is closely related to Amae. Even now, compared to young people in Western societies, young people in Japan tend to be more economically dependent on their parents, and this phenomenon seems to be one of the expressed forms of Amae. Hikikomori may be indirectly promoted by overprotectiveness and Amae, which makes parents accept their child staying at home.

d) Stronger mother-child and weaker father-child relationships (ambiguity of male role in Japanese society)

In Western society, fathers' roles, represented in the Oedipus complex, are strong, while in Japan, these Oedipal situations are less pronounced. Perhaps in western society, if a son or daughter were to withdrawn from school and society, their father would strongly encourage them to go out. In Japan, however, it would be uncommon for the father to play this role.

e) Emphasis on collectiveness and less value placed on individualism

Traditionally, in Japan, collectiveness has been strongly emphasized, and less value has been placed on individualism. In the 20th century, Japan was significantly influenced by Western cultures. Using Western cultures as models, Japan has grown rapidly, catching up with the West and overtaking it economically and technologically. Moreover, Western ideals such as separation and independence have become popular, while ideals originally rooted in Asian cultures, such as cooperation, dependency, and "emotional dependence," have subsequently lost their value. Japan currently incorporates mixed cultural values, and in this context, hikikomori may easily emerge.

f) High-pressure educational system (exam war, or Juken Sensou)

g) Schooling Issues: Bullying (Ijime), Truancy or refusal to attend school (Futoukou)

Regarding (f) and (g), the movie "Left handed (SIZE, Japan 2008)" depicts hikikomori and the somewhat pathological schooling system in Japan. In Japan, suicide by bullying is another emergent issue. These problems in the school environment result not only in hikikomori but also in the recent increase in youth suicide.

I propose that the above-mentioned sociocultural factors make it easier for hikikomori to emerge in Japan.



World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

(cont'd 2)

II. International Influences (Globalization and internet-connected society)

Now that we can observe people with hikikomori outside of Japan, such as in France, India, Italy, Oman, South Korea, Spain and the USA, we should explore the contextual reasons why hikikomori has appeared outside of Japan. What does this phenomenon indicate? In my opinion, worldwide shifts towards similar lifestyles and societies, otherwise called “globalization,” are underlying factors in the growing hikikomori phenomenon outside Japan.

Technological developments such as the Internet and video and web-based games have de-emphasized the need for direct, face-to-face human contact. In Japan, 1983 was an important year because it was the year when the Nintendo home video game system (called FAMICOM) was first released and when children were first exposed to home video games. These children became adolescents and young adults in the mid-1990s. Is it not interesting that this is around the time when the pandemic of hikikomori occurred, as described in the late 1990s?

Modern societies with less direct, face-to-face communication may facilitate living as hikikomori (Kato et al. Lancet 2011). Indirect communication is somehow accepted and sometimes welcomed in Japanese society, which is one reason why hikikomori may have existed in Japan even several decades ago. Traditionally, Japanese society has relied on interpersonal relationships. On the other hand, Western society has been based on individualism. Recent globalization, furthered by novel technologies such as the Internet, has led to societies with mixed values, which in turn has contributed to hikikomori in other countries, including in the West.

How often do patients with hikikomori require mental health evaluation? In our understanding, people who are socially withdrawn are reluctant to visit mental health professionals. What do you think the obstacles have been in preventing them from seeking professional help?

In a vignette study that we recently conducted revealed that approximately 30% of people who are socially withdrawn have some kind of psychiatric disorder (Kato et al. Soc Psychiatry Psychiatr Epidemiol 2012), whilst even higher rates have been reported in other research. A sense of shame may be raised as a reason that people who are socially withdrawn are reluctant to visit mental health professionals. This reluctance sometimes stems not only from the individual but also from parents. In Japan, clinical research focusing on hikikomori has been developed and conducted mainly by the Japan's Health, Labor and Welfare Ministry, resulting in the publication of the treatment guidelines of hikikomori by Dr. Toshikazu Saito and his colleagues. Various types of hikikomori Support Centers have widely been established in cities and prefectures in Japan. Telephone supports and Parental support groups are highly active in these centers. Continued and increased cooperation will further develop strategies to support people with hikikomori. My colleagues and I are currently collaborating with Fukuoka Municipal Mental Health and Welfare Center to conduct research on new effective approaches for caring for people with hikikomori.

If these patients require specialized intervention, what services and/or treatments could be recommended to mitigate their difficulties? What could be the role of child and adolescent psychiatrists caring for these populations in real-life practice?

Some people with hikikomori have a diagnosis of ASD or schizophrenia; thus, insuring an accurate



World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

(cont'd 3)

psychiatric diagnosis is especially important. However, the problem remains that many people with hikikomori hesitate to seek medical assistance. To combat this challenge, home-visits are effective, and some institutions in Japan have experience with conducting such visits. Recently, this approach has also been reported in other countries such as South Korea and Spain. As truancy among school children often leads to hikikomori, early intervention implemented by child psychiatrists in cooperation with schoolteachers may be a key strategy. Psychotherapeutic approaches, especially group psychotherapy, may also be effective for children at risk for hikikomori.

How do you envision the impact of hikikomori on future clinical practice and research in child and adolescent psychiatry?

In general, when we speak of hikikomori, there may be an impression that it is something uniquely related to Japanese society/culture. However, if we consider hikikomori from the perspective of social isolation, it is indeed not limited to Japan, but is, rather, a universal theme, especially as Internet gaming and Facebook have diminished face-to-face communications. Ironically, fear of social isolation itself may be a motivation to use such tools. We recently organized a symposium focusing on social isolation during the World Congress of Psychiatry in Madrid 2014 (Photo). Dr. Renato D. Alarcón (Mayo Clinic College of Medicine, Rochester, USA/Universidad Peruana Cayetano Heredia, Lima, Perú) presented a review of social isolation in the DSM-5. Dr. Terry Brugha (University of Leicester, UK) presented an epidemiological study on the impacts of loneliness in psychiatric illness (Meltzer et al. Soc Psychiatry Psychiatr Epidemiol 2013). My research collaborators, Dr. Masaru Tateno (Sapporo Medical University/Tokiwa Child Development Center, Japan) and Dr. Alan R. Teo (Portland VA Medical Center/Oregon Health & Science University, USA), introduced a multifaceted approach to understanding hikikomori. Dr. Tateno explained the correlation between ASD and hikikomori (Tateno et al. BMC Psychiatry 2012). Given the comorbidity between ASD and hikikomori, involvement of child psychiatrists in evaluation and management is absolutely necessary. Dr. Teo presented the results of an international survey that showed the existence of hikikomori in the USA, Japan, India and South Korea (Teo et al. Int J Soc Psychiatry 2014). While current research on hikikomori has focused on psychosocial and cultural perspectives, I presented novel translational research on biological vulnerabilities and blood biomarkers to identify risks for hikikomori.

We hope that, as hikikomori research becomes more global and more translational, we will find, in the near future, effective prevention strategies and treatments.

Dr. Kato was interviewed by Dr. Hirota (Assistant Editor).



(cont'd 4)

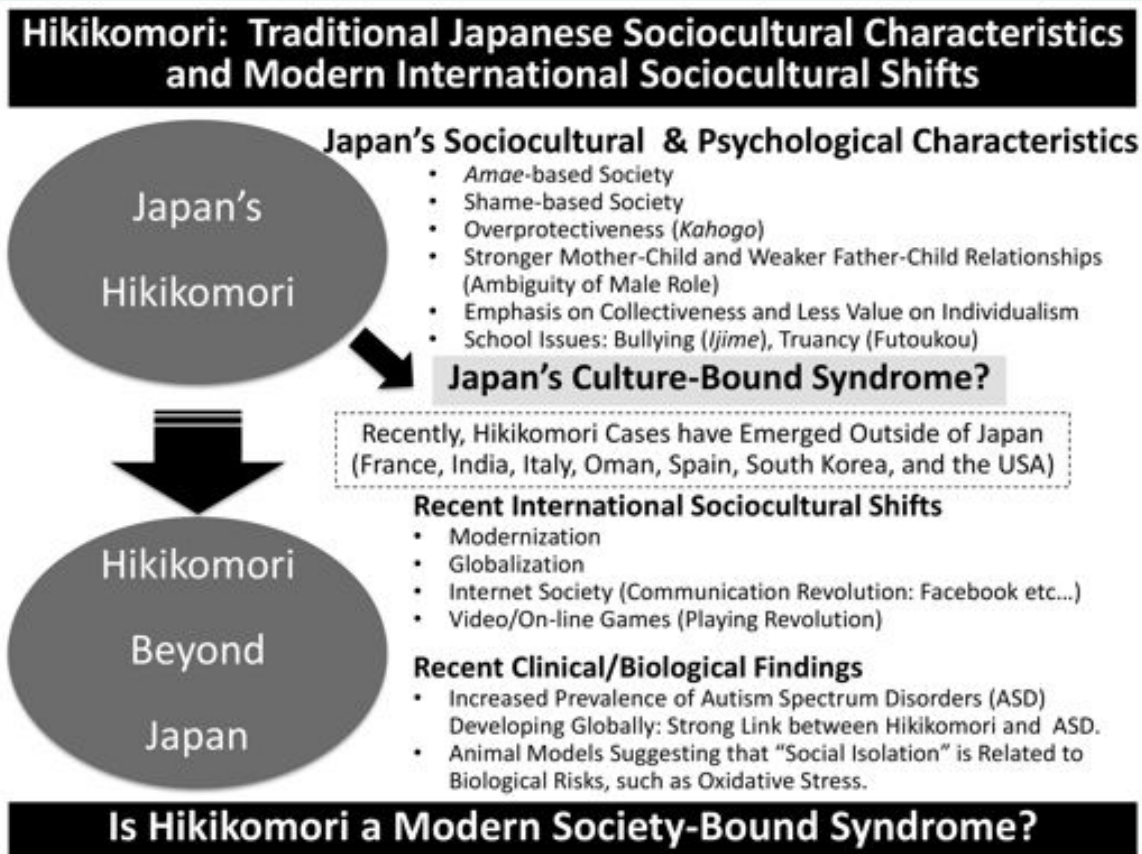


Figure: Understanding of hikikomori from multi-dimensional aspects



Group photo at the symposium "Social Isolation" in the 14th World Congress of Psychiatry, 17 September 2014, Madrid, Spain. (From left side: Dr. Kato, Dr. Tateno, Dr. Brugha, Dr. Alarcón, Dr. Kanba, and Dr. Teo)



World Child & Adolescent Psychiatry

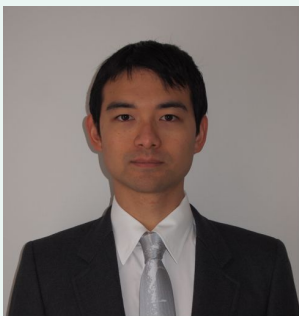
ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

Trainees Corner

The Road to Becoming a Child and Adolescent Psychiatrist in Japan

Dr. Hidekazu Kato (Japan)



When I was a medical student, I read a book about theory of mind in autism and became attracted to the inner psychic world of children with autism. From that point on, I wished to become a child and adolescent psychiatrist mainly involved in the care of patients with autism spectrum disorder, but I wondered how I could achieve this goal.

In Japan, the system of medical specialists began in 1962 with recognition of the specialty of anesthesiology. Subsequently, other specialties were established and organized through their respective academic societies. However, because of a lack of national standards, many of the specialty training programs in Japan are not well structured and are variable in quality. To improve the system of training medical specialists, the Japanese Medical Specialty Board was established in 2014, and the new system will start in 2017.

Child and adolescent psychiatry is one of the fields not widely recognized in Japan. With no established pathway leading to this career, many trainees become lost and subsequently give up on becoming a child and adolescent psychiatrist. I believe there are three reasons why the child and adolescent psychiatric career pathway has not yet been well established in Japan. Firstly, even in universities, few departments or divisions of child and adolescent psychiatry exist; therefore opportunities for research and clinical training in this specialty are limited. Secondly, the academic societies for child and adolescent psychiatry are not unified, with pediatricians and psychiatrists (who each pursued parallel career paths towards child and adolescent psychiatry) belonging to different societies. I hope that the new unified system (to start in 2017) of child and adolescent psychiatric specialization will resolve this confusion. Finally, there are few job opportunities for child and adolescent psychiatrists. The clinical practice of child and adolescent psychiatry does not produce much revenue, so few medical institutions provide child and adolescent psychiatric services. Even if you were certified as a child and adolescent psychiatrist, it would be difficult to actively practice that specialty. Fortunately, in the past few years, government-determined reimbursement for child and adolescent psychiatric services has slightly improved.



World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

Trainees Corner (cont'd)

Dr. Hidekazu Kato (Japan)

Currently, there are three ways to become a child and adolescent psychiatrist in Japan: via two or three years of subspecialty training following three years of general psychiatry training (which is the most common pathway); via three years of child and adolescent psychiatry training following two years of internship or postgraduate mandatory clinical training; or via the two or three years of subspecialty training following three years of pediatric training (which is the pathway I have chosen).

From my perspective, the advantages of pursuing child and adolescent psychiatric training following pediatric training include: a deep understanding of normal child development and the biological aspects of medical illnesses; awareness of the psychological impacts of medical illness on both patients and family members; and enhanced ability to detect treatable biological etiologies in patients with neurodevelopmental disorders, such as fragile X syndrome, tuberous sclerosis and creatine deficiency syndromes.

Through psychiatric training that I am currently undergoing, I have realized that social contexts can play an important role in real-world clinical practice. Perceptions of mental illness vary from society to society, and some mental health issues such as school absenteeism and hikikomori (prolonged social withdrawal especially prevalent in Korea and Japan) are considered to develop in the social context. These phenomena have important implications for educational, welfare, and healthcare services. It is my ambition to become a child and adolescent psychiatrist with a broad bio-psycho-social view that can help youth with complex conditions.



World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal



Preconference workshops:

- Children And Disaster, lessons from the Malaysian Mental Health Team in dealing with the MH 370 & MH 17 crises
- Children And Their Family
- Children With Developmental Disabilities
- Mindfulness-Based Stress Reduction
- Psychodynamic Psychotherapy

Symposium:

- Adolescent Psychosis
- Children And Trauma
- Childhood Autism
- Children And Trauma
- Child Abuse And Neglect
- Conduct Disorder And Risk Of Re-Offending
- The Role And Use Of ICT In Children
- The Use And Role Of Medication In Children

Further information regarding congress will be available soon at www.ascapap2015.com.



World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal



WPA REGIONAL CONGRESS OSAKA Japan 2015

Asian Partnership in the World

<http://www.congre.co.jp/wpa2015>

hosted by the Japanese Society of Psychiatry and Neurology



In association with

The 111st Annual Meeting of
the Japanese Society of
Psychiatry and Neurology (JSPN)

Your Partnership for Psychiatry and Neuroscience in the World

<http://www.congre.co.jp/jspn111>

June 4 (Thu) — 6 (Sat), 2015 Osaka, Japan

• Osaka International Convention Center • RIHGA Royal Hotel Osaka

WPA OSAKA REGIONAL CONGRESS 2015

Congress President: Dinesh BHUGRA, WPA President
Congress Director: Masatoshi TAKEDA, JSPN President
Secretary General of the Congress: Tsuyoshi AKIYAMA

The 111st Annual Meeting of the Japanese Society of Psychiatry and Neurology (JSPN)

Chair: Toshitomi KISHIMOTO, Nara Medical University
Vice-Chair: Molchanu HIRAI, Japan Psychiatric Hospitals Association



World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

Last Announcement & call for abstracts

The 11th International Conference on Psychiatry “Translational Psychiatry; From Science to Practice”

Intercontinental Hotel, Jeddah, Kingdom of Saudi Arabia, 16 – 18 April 2015

Saudi German Hospital & Saudi Psychiatric Association

In collaboration with:

- Psychiatric Hospital Jeddah.
- Motmaenna Psychiatric centre
- Institute of Psychiatry Ain Shams University
- Egyptian Psychiatric Association.
- Kasr Al-Ainy Psychiatry Department, Cairo University.
- World Psychiatric Association

Website: http://jed.sghgroup.com.sa/index.php?option=com_content&view=article&id=293&Itemid=42&lang=en

Preliminary Topics

1. Theme of the conference Translational Psychiatry from Science to Practice.
2. Role of Culture in clinical practice both in prevention & treatment.
3. Arab Mental Health services: Service Development, Policies, Pathways to Care/Healthcare economics.
4. Liaison Psychiatry.
5. Psychosis: Early intervention and improving outcome.
6. Mood Disorders: Depressive disorder & Challenges in the management of Bipolar Disorder.
7. Personality, Eating, and Psychosexual Disorders.
8. Child & Adolescent Psychiatry
9. Old Age Psychiatry: functional & organic mental disorders in old age.
10. Therapeutic Approaches in Mental Health: Bio-Psych-Socio-Spiritual.
11. Role of Culture in clinical practice both in prevention & treatment.
12. Brain Imaging in the diagnosis & management of mental disorders.
13. Medical ethics, Religion & Spirituality in the era of Globalisation.
14. Advances in the field of Medical Education & Psychiatric Training.
15. Stigma of Mental illness & role of media in promoting positive public opinion.
16. The interface between Psychiatry, Psychology, Philosophy and Social sciences.

Deadline for submission: 01.12.2014





World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

IRCCS FATEBENEFRATELLI - BRESCIA (ITALY)

European Conference on
YOUTH MENTAL HEALTH:
FROM CONTINUITY
OF PSYCHOPATHOLOGY TO
CONTINUITY OF CARE
(STraMeHS)



"This conference arises from the project YOUTH MENTAL HEALTH: FROM CONTINUITY OF PSYCHOPATHOLOGY TO CONTINUITY OF CARE (STraMeHS) which has received funding from the European Union, in the framework of the Public Health Programme."

**16-18
DECEMBER
2014
VENICE
SAN SERVOLO
CONGRESS CENTRE
ITALY**

www.youthmentalhealth2014.eu



World Child & Adolescent Psychiatry

ISSUE 7, December 2014

WPA, Child and Adolescent Psychiatry Section's Official Journal

World Child & Adolescent Psychiatry

WPA, Child and Adolescent Psychiatry Section's Official Journal

Editor: Prof. Norbert Skokauskas (Norway) N_Skokauskas@yahoo.com

Assistant Editors: Prof. Anthony Guerrero (USA), and Dr. Jibril Abdulmalik (Nigeria), Dr. Tomoya Hirota (Japan, USA)

Editorial Board: Prof. Bennett Leventhal (Chair, WPA CAP, USA), Dr. Gordana Milavic (Co-Chair, WPA CAP, UK), Prof. Dimitris Anagnostopoulos (Past Chair, WPA CAP, Greece), Prof. S.Malhotra (India), Prof. D.Fung (Singapore), Prof. S.Honjo (Japan), Prof. P.Szatmari (Canada), Prof. L.Viola (Uruguay), Prof. S.C.Cho (S.Korea), Prof. D.Puras (Lithuania), Dr. V.Storm (Australia), Dr. J.Fayyad (Lebanon), Dr. S.Tan (Malaysia), Dr. M.B.Moyano (Argentina), Dr. N.V.Tuan (Vietnam), Dr. T.Masaru (Japan), Prof. Paramjit Joshi (USA), Prof. Andre Sourander (Finland), Prof. Edgard Belfort (Venezuela), and Prof. John ("Jack") F. McDermott, Jr. (USA).