



World Child & Adolescent Psychiatry

ISSUE 6, April 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 World Psychiatric Association, Child and Adolescent Psychiatry section (WPA CAP).

Our Association (WPA) is an association of 135 national psychiatric societies, spanning 117 different countries and representing more than 200,000 psychiatrists. We aim to increase knowledge and skills necessary for work in the field of mental health and in the care for the mentally ill.

WPA CAP is growing rapidly. "World Child and Adolescent Psychiatry" is committed to disseminating news in support of the growing importance of child mental health on the world stage. While "state-of-the-art" clinical practice research in child mental health is carried out almost exclusively in high-income countries, it is our goal to advocate for children in all countries of the world and to make sure that, through our global educational, mentorship, and networking efforts, as many as possible children can receive care from a workforce knowledgeable about the latest developments in our specialty. WPA CAP Group on Teaching and Learning is one of the most active groups in our section, and it closely collaborates with other organizations. I would like to acknowledge several members of the group who have, over the past several years, contributed significant time and energy: Prof. Anthony Guerrero (USA), Prof. Jeffrey Hunt (USA), Prof. Daniel Fung (Singapore), Dr. Say How Ong (Singapore), Dr. Masaru Tateno (Japan), Prof. Cynthia Santos (USA), and many others.

As always I would like to thank all authors in this issue and my editorial team: Prof. Bennett Leventhal (WPA CAP Chair), Prof. Anthony Guerrero (Assistant Editor, Honolulu, USA), Dr. J. Abdulmalik (Assistant Editor, Nigeria), Dr. G. Milavic (Co Chair WPA, CAP, UK), A. Prof D. Fung (Singapore), Dr. M. B. Moyano (Argentina), Prof. D. Anagnostopoulos (Past Chair, WPA CAP, Greece), Dr. M. Tateno (Japan), Dr., Prof. S. Malhotra (India), 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. N. V. Tuan (Vietnam), Prof. Paramjit Joshi (USA), Prof. A. Sourander (Finland), Prof. Dr. E. Belfort (Venezuela) and Prof. John "Jack" McDermott Jr. (USA).

And last but not least I would like to welcome the youngest member of our Editorial Board: Dr. Tomoya Hirota, a Japanese doctor undergoing psychiatry training in the USA who will take responsibility for the trainees section.

Happy readings!

Prof. Norbert Skokauskas, Norway
Editor, "World Child and Adolescent Psychiatry"
Secretary, World Psychiatric Association, Child
and Adolescent Psychiatry Section

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



"Too Big to Fail? Too Small to Survive?"

During the recent economic crisis, multi-billion dollar corporations were deemed "too big to fail." As a result, governments spent hundreds of billions of dollars to save General Motors, The Royal Bank of Scotland and JP Morgan Chase, to mention but a few. Economist Ross Sorkin even wrote a book entitled *Too Big to Fail* that was made into an award winning film, starring William Hurt, James Wood, Ed Asner, and Paul Giamati. What was the big deal, and what is the relevance to Child and Adolescent Psychiatry?

Well, the "big deal" about *Too Big to Fail* was that it represented the real power of real power. It demonstrated that power and a perception of jeopardy can lead to extraordinary actions that protect those who put themselves, and us, at risk. Certainly, inappropriate risk-taking and thrill-seeking are amongst our clinical concerns in Child and Adolescent Psychiatry. Perhaps the financial regulatory authorities should have consulted a Child and Adolescent Psychiatrist for assistance in managing the bad behavior and inattention that precipitated the financial crisis. We actually might have been helpful, but the notion is ridiculous because they never would have considered us to be useful; even if they did think of us, we likely would be too busy to offer a timely appointment. And, would we accept their insurance? This lack of knowledge about what we do and mundane logistical matters isolate Child and Adolescent Psychiatry from real power.

Otherwise, the financial crisis hardly seems relevant to us in Child and Adolescent psychiatry, as we make so little money and apparently contribute such a small amount directly to the economy of any particular nation and the world as a whole. Indeed, in some countries, there are so few of us that no one knows we exist. Even in larger countries, we are essentially irrelevant to the health care system. If that were not enough, where there is even a modicum of concern about children's psychiatric illnesses, we are often confused with other professionals like psychologists, social workers, and child therapists. As I have suggested previously, those in power often have no clue about who we are, what we do, and/or where to find us.

What lessons can we learn from the recent – and ongoing – financial crisis? Well, it boils down to this reality: if we, as Child and Adolescent Psychiatrists, are small in number and perceived to be of little consequence to healthcare systems, we can and will be allowed to fail. Child and Adolescent Psychiatry is so small and so isolated that it is hardly relevant to the overall care of children and to medical colleagues who are replacing us with psychologists and social workers. Just look around in your community, clinics, and hospitals. Can't we see the handwriting on the wall? Does anyone ask about what happened to the venerable Wall Street firm, Lehman Brothers? Do they care that JP Morgan now belongs to Chase or that the Royal Bank of Scotland is owned by the British Government? Not really! And, unless we promptly do something meaningful, "they" won't really remember Child and Adolescent Psychiatry.

How did this happen to us? What keeps Child and Adolescent Psychiatry so small and, to a large extent, irrelevant? Unfortunately, the answers to these questions are simple:



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Prof. Bennett L. Leventhal
Chair's Column (cont.1):

1. Recruiting

We rarely play a central role in medical education and health care, and we even more rarely participate in the selection of students entering medical school and advanced training programs. Therefore, we cannot advocate for students who might be interested in our work. We are also nearly invisible in early medical student coursework. In other words, we are generally not available to serve as “role models” and mentors for developing physicians.

2. Training

There is not an international standard defining Child and Adolescent Psychiatry, its knowledge base, and its essential practice skills, especially those skills that are unique to our roles as physicians. As a result, our training programs are widely varied, and training standards keep adding elements without either considering their necessity to our professional definition or removing elements that are no longer relevant to our unique medical subspecialty practice. And, for many who look closely at our training, it is not at all clear how our practice is different from that of other disciplines, both within and outside of medicine.

3. Practice

The practice of Child and Adolescent Psychiatry is often isolated from the rest of medicine. Many practitioners are in private office practices and rarely have professional interactions with other physicians. When we work for hospitals or medical centers, we are often in “other” buildings or even on campuses that are far removed from our other medical colleagues. With our lack of medical skills, and without seeing us around, our colleagues are replacing us with social workers, psychologists, advanced practice nurses, pediatricians, neurologists, developmental pediatricians, and all manner of other “mental health professionals” who either meet their needs or allow them to say that they have “mental health services.” And, if that were not enough, we have not identified our unique set of medical skills so that we are seen as invaluable by our colleagues and essential to the health care system.

4. Research

We have failed to develop and “own” our science. Our training programs give short shrift to research training, and there are few provisions for research career development for Child and Adolescent Psychiatrists. As a result, there are remarkably few Child and Adolescent Psychiatrists dedicated to full – or even half-time – research careers. We have not organized systems for training scientists, in part because we do a poor job of defining the science underlying our discipline and/or deferred much of our basic science to other medical and non-medical specialties.

5. Economics

We are more expensive than other “mental health” providers of care and have not done a good job of explaining why this is the case. Certainly, it is more expensive to be educated as a physician, but since we have not defined how we are different from non-medical specialists, why should healthcare systems pay more for our services?



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

6. "Too small to survive"

At the moment, we in Child and Adolescent Psychiatry is divided in so many ways, leaving the perception and reality that Child and Adolescent Psychiatry is "small"... so small that our very survival is at risk. As other disciplines grow and speak in a single voice, Child and Adolescent Psychiatry remains divided into an alphabet soup of professional organizations (e.g., WPA CAP, IACAPAP, AACAP, ESCAP, ASCAPAP, EMACAPAP, and a myriad of national/state "societies," "associations," and "colleges.")

These groups not only compete with each other but, at times, they disparage one another. Such divisiveness means that we are perceived as a "house divided" into even smaller and less important parts. Our divided house limits the clarity and power of our messages about the relevance and importance of our specialty in the treatment of child and adolescent psychiatric disorders.

While some may argue against a few of these facts, the realistic ones among us know that what I am saying is not far from the truth. While it is not yet clear whether we are "too small to survive," is this the time to start writing our epitaph? I think not. But, I am well aware that some, especially professionals in other disciplines, are ready to or have done so. This situation leads to two options: (1) continue down the same path or (2) determine what we can and will do.

It will be very challenging and time-intensive – requiring considerable determination, creativity, and flexibility – to make us initially "big enough to survive" and eventually "too big to fail." To do so, we must immediately:

1. Re-define our discipline with clear answers to the questions: Who are we? What do we do? What is our unique role in medical practice and in the healthcare system?

2. We must clearly distinguish ourselves from the other "mental health providers."

3. We must make it clear that we are physicians who specialize in the medical sub-specialty of Child and Adolescent Psychiatry and who diagnose and treat real disorders of developmental psychopathology in real patients by using real evidence-based, scientific practice.

4. We must behave like other medical specialists in assuming accountability for patients' well-being, including amongst other things: be available to help our patients and colleagues in emergencies; manage privacy concerns so we can communicate frequently and effectively with colleagues; use technology (telemedicine, computer/app-based interventions) without compromising our quality standards; and seek feedback from our colleagues about what helps and what doesn't. (I am pleased the editors chose this issue for an interview with pediatrician, Dr. Jane Foy, on the interface between pediatrics and Child and Adolescent Psychiatry).

5. We must do a better job of recruiting the best candidates into our training programs.

6. We must quickly alter our training programs to reflect the changing needs of our science and practice, as well as the needs of the healthcare systems in which we work.



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Prof. Bennett L. Leventhal

Chair's Column (cont.3):

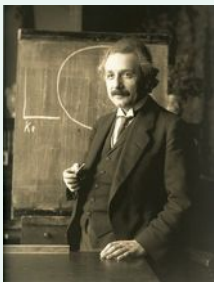
7. We must also alter our practice and develop economic models that support the highest quality of evidence-based practice.

8. We must increase the number of high quality child psychiatric researchers who can provide us with the evidence-base for our practice.

9. We must unite the disparate groups into a single force that can speak in one voice about the substance, training, research and practice of Child and Adolescent Psychiatry so as to change the perception that we are small and unimportant.

These steps will not be easy but we **can** take them, if we choose. If we succeed, we can become an important part of the evolving world healthcare system. We must act with urgency to prevent staying "too small to survive." We at WPA CAP are determined not to be "too small to survive." We are prepared to consider any and all options, including forming a formal confederation, merger or any other framework that will work to meet our challenges. This cannot wait until another annual, bi-annual or triennial meeting. It must happen now. But, who will join us in this fight for survival? We hope to hear from you soon.

"If I were to remain silent, I'd be guilty of complicity." -



Albert Einstein

14 March 1879 – 18 April 1955



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YOUTH MENTAL HEALTH: FROM CONTINUITY OF PSYCHOPATHOLOGY TO CONTINUITY OF CARE (STraMeHS). AN EUROPEAN CONFERENCE, VENICE, 16-18 DECEMBER 2014

Drs. Giovanni de Girolamo, Jessica Dagani, and Giulia Signorini (Italy)

HEALTH AND ILL-HEALTH AMONG YOUNG PEOPLE:

Young people aged 10–24 years represent 27% of the world's population. Important health issues and risk factors for disease occurrence in later life emerge in those years, and their contribution to the global burden of disease is relevant. Using data from the World Health Organization's (WHO) 2004 Global Burden of Disease study, Gore et al. (2011) calculated cause-specific disability-adjusted life-years (DALYs) for young people aged 10–24 years on the basis of available estimates for incidence, prevalence, severity and mortality. Between the eight main causes of DALYs in this age groups, the majority were psychiatric and behavioural in nature. Furthermore, cross-sectional studies have shown that the exposure to risk-factors in childhood and adolescence increases the probability of developing mental health disorders in adulthood (Kessler et al., 2010).

Temporal trends in incidence rates of mental disorders among adolescents and young people are a highly debated area. While there is evidence of increased rates of substance abuse (Degenhardt et al., 2013) and suicide (Patel, 2012) over this last decade, the case of depression is more controversial, as some authors have argued that rates of depression did not increase in the last 30 years (Costello et al., 2006). Rates of schizophrenia have not decreased, and there has been an increase in the rates of substance-induced psychosis over time (Kirkbirde et al., 2009). These data again highlight the need for improved mental health care in these 'transition to adult years'.

THE CONTINUITY OF PSYCHOPATHOLOGY:

Many studies have shown a high degree and type (i.e. homotypic and heterotypic) of continuity of psychopathology from childhood to middle adulthood (Rutter et al., 2006), and underscore the need to study psychopathology through a developmental perspective.

However, there are important reasons for positive resolution expectations, as shown by a recent, landmark study by Patton et al. (2014) in which they evaluated patterns and predictors of persistence of problems into adulthood in a stratified, random sample of 1,943 Australian adolescents followed up for about 15 years. Longer duration of mental health disorders in adolescence was the strongest predictor of clear-cut young adult disorder and adolescents with a background of parental separation or divorce also had a greater likelihood of having ongoing disorder into young adulthood than did those without such a background. Rates of adolescence onset disorder dropped sharply by the late 20s, suggesting a further resolution for many patients whose symptoms had persisted into the early 20s.

The resolution of many adolescent disorders gives reason for optimism, suggesting that interventions which shorten the duration of episodes could prevent much morbidity later in life. This study also underscores the need for an intensive investigation of the course of disorders during the developmental phase, and a close scrutiny of factors protecting against persistence of disorders.



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(cont.1)

IS CONTINUITY OF CARE IN PLACE?

If many mental disorders continue across different developmental stages, do mental health services guarantee continuity of care? In general only a few young people (less than one in six) with mental disorders access services or receive appropriate care (Kataoka et al., 2002). The current service configuration of distinct Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS) is a barrier to providing continuity of care, but barriers to transition are not restricted to age boundaries alone. Research findings indicate conceptual, clinical, and ideological differences between CAMHS and AMHS in relation to thresholds regarding acceptance criterion, professional differences and service structures/configurations which were found to be an impediment to continuity of care for young people, especially those who make a transition from one system of care to another (Singh, 2009). For these reasons, current service configuration of CAMHS and AMHS has been described as the “weakest link in a system where it should be most robust” (McGorry, 2007).

As no conference in Europe, up until now, has discussed these specific problems and the strategies needed to achieve effective transitional care, we submitted a proposal for having a conference on the issue of transition and youth mental health to the Executive Agency for Health Consumers (EAHC) of the European Commission. Recently the application was deemed important and approved, and the Conference on YOUTH MENTAL HEALTH: FROM CONTINUITY OF PSYCHOPATHOLOGY TO CONTINUITY OF CARE (STraMeHS) will be held in Venice on December 16-18, 2014.

The STraMeHS Conference aims at raising awareness and improving mental health providers, policy makers, decision makers and health administrators' knowledge about youth mental health and factors affecting this area. In addition, a second important objective is to identify and promote the development of integrated models of care and functioning of CAMHS and AMHS, with a specific focus on strategies and procedures on how to foster appropriate and timely transition from CAMHS to AMHS. A third aim is to promote the implementation of quality assurance programmes aimed at improving outcomes, quality of life, and overall health status of young patients needing transitional care.

A FORUM FOR A DISCUSSION:

Thanks to the active participation of a large number of experts in child and adolescent and adult psychiatry, pediatricians, mental health workers, policy makers and representatives of users and of their families from all 28 European countries, as well as of a selected number of experts and stakeholders from extra-European countries, the Conference will help to map current services and transitional policies across EU, develop and propose transition-specific outcome measures and promote the discussion on innovative transitional care models.

Target participants will be the members of Europe's foremost professional associations and patient and caregiver associations working in the mental health field, as well as key policy makers and administrators. The topic of the STraMeHS Conference focuses on one of the five priorities selected by the “The European Pact for Mental Health and Well-Being” (EU High-Level Conference, Brussels 2008); which underlined that mental health in youth is a key factor for societal growth and cohesion. The conference is also in line with the objectives of the Second Programme of Community Action in the Field of Health in generating and disseminating health information and knowledge.



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(cont.2)

This event has a great potential for positively impacting policy, services and research-related areas, opening the way for a substantial reorganization of CAMHS and AMHS across EU and strengthening the weak link between CAMHS and adult care. This international initiative will expand health research system linkages for multidisciplinary and cross-sectoral research, addressing the needs for innovative models of transition in pediatric care or social services, which often face very similar problems, and paving the way for efficient transition management policies without increasing expenses, possibly safeguarding the efforts made in the CAMHS. Thanks to the active contribution of a large number of stakeholders, the European Conference in Venice can represent a significant step forward to enhance health and mental health of children and adolescents and contribute to the achievement of the health priorities indicated by the European Commission in the last years.

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



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Interview with Dr. Joaquin Fuentes

Dr. J. Abdulmalik (Assistant Editor, Nigeria)

Introduction:

Dr Joaquin Fuentes is one of the global giants in the world of Child and Adolescent Psychiatry, whose area of interest is Autism Spectrum Disorder (ASD). He currently serves as the Head of Child and Adolescent Psychiatry, Policlínica Gipuzkoa in Donostia/San Sebastián, Spain. He has also been instrumental to the development of GAUTENA, a community initiative for people with Autism Spectrum Disorder (ASD) in the Basque Country of Spain, and he currently serves as a Research Consultant to the Organization.

In recognition of his tremendous contributions to the health and development of not only his community, but indeed to his country, region and internationally, he was recently honored with the highest recognition of his home town of Donostia /San Sebastian: the 'Golden Drum' award for fostering bonds of knowledge and friendship with other countries, cities, institutions and people".

Dr Fuentes serves on different editorial boards in international journals on autism and has been an advisor for Autism Europe, as well as serving as the scientific co-ordinator of the Autism Spectrum Disorder Study Group of the Institute of Health, Carlos III, Spain.

"World Child and Adolescent Psychiatry" was privileged to have gained his consent to share his wealth of experience with our readers, and this is presented below.





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Interview with Dr. Joaquin Fuentes (cont'd 1)

1. You are undoubtedly one of the global leaders in the world of CAP today. Our readers would like to have some idea about your background, including your education and professional training. In what ways have your international training and exposure impacted on your career trajectory subsequently?

I may say that I became international from the beginning. After graduating from Medical School and completing my internship rotations in my home country of Spain, I spent four years in the USA, completing my Psychiatry Residency in Albany, New York, and my Child Psychiatry Fellowship in Pittsburgh. That experience certainly opened my mind to other realities and improved my English language! Subsequently, it was only natural to foster relationship with other colleagues. Indeed, with the mentoring support of Donald J. Cohen, a giant in our field, I started my involvement with European and global organizations. That journey has enriched my experience and I have tried to enrich the lives of others too, both locally and abroad, in many countries of the world.

2. In addition to your clinical and academic/research interests, what other activities and organizations have you been actively engaged with?

I have had the privilege of contributing to the development of a comprehensive community program for people with autism and their families in my region of Spain. This has given me the opportunity to give invited conferences and courses in more than 30 countries of all continents. This disseminating effort always pays back. There are good and bad things all over the world and I try to point out the strengths of the places I visit and try to help them to use those strengths, adapting from our experience, to profit from the opportunities they have. My advisory role in Autism Europe has really given me tremendous possibilities to influence our field.

3. You are widely respected as a mentor for young professionals all over the world. What motivates you to nurture younger colleagues and to encourage them as much as you have been doing over the years?

My wish is that mentees become more successful than their mentors. They should not be like us, they should become better! And I respect the Hippocratic Oath, which stipulates that you must impart the knowledge of this art. I often say, and believe this to be true, that by teaching you learn much more than from being taught. So mentorship is brilliant, because it helps you also to learn from others. Considering the scarcity of resources that most children and adolescents of the world have access to, mentoring becomes an ethical imperative. I truly enjoy this and I have had the incredible luck of mentoring dozens of young colleagues in the AACAP meetings, and more that 300 young mental health professionals from all over the world in the IACAPAP Donald J. Cohen Fellowship Program, with my good friend Prof. A. Martin and others.

4. In your opinion, what are the greatest challenges for CAP in today's world?

The biggest challenge, as I see it now, is to build strong bonds with other human services through effective inter-sectoral collaborations. We know quite a lot about development and mental problems in children and adolescents. But we risk keeping this knowledge for ourselves, and the number of kids with difficulties makes it impossible to provide direct services. We have to embed ourselves within the initiatives of the communities. A global CAP must be transversal, impacting and benefiting from both local and general actions.



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Interview with Dr. Joaquin Fuentes (cont'd 2)

5. What roles should CAP organizations, such as WPA-CAP Section and others be playing in a bid to achieve these goals? What recommendations would you proffer?

I think that we need collaboration and mutual empowerment. We need to avoid isolation and again, act jointly in promoting mental health and treating mental disorders, while utilizing the natural resources that every community does possess. We need to have a shared global vision, but we should promote acting locally.

6. Looking forward, are there causes for optimism about CAP services in the world?

That is difficult to say. Natural disasters, wars and their consequences, social changes, poverty, discriminating cultural aspects in some parts of the world....these are occurring along with scientific and human growth in other parts of the world. I fear that the differences in services are more and more striking. So, there may be optimism in some countries and pessimism in others. The role of international organizations should be to balance this; to make the world a better place for all children.

7. In conclusion, what are your future plans for CAP? What would be your parting words to our readers and indeed, to all committed CAP mental health professionals across the world?

I am active in IACAPAP, as one of the vice presidents, and I have been appointed to the AACAP Presidential Initiative, aimed at fulfilling the international responsibility of the American Academy, the strongest organization in CAP in the world. These are exciting and important opportunities, and I hope that I will serve them well. I will always be surrounded by committed professionals....that is the trick. Do not do anything alone. You need a team, and there are teams all over the world. Relate, share, and learn from other colleagues. You will become a better professional and a better person. That is the beauty of our job. Enjoy it.

Dr. Fuentes was interviewed by Dr. Abdulmalik,



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Developmental Phases of a 30-year Research Career in Korean Child and Adolescent Psychiatry: Self-reflections and the Case for a Bio-psycho-social-spiritual Model



Prof. Soo Churl Cho (S.Korea)

In this paper, I propose a Bio-Psycho-Socio-Spiritual model in the field of child psychiatry based on my 30-year experience in child and adolescent psychiatric research. In reflecting upon my career, I identify nine distinct developmental phases: The first phase focused on reliability and validity studies for the objective assessment of child psychiatric disorders. Sample publications included: "Development of Korean form of CDI (Children's Depression Inventory)(1989)" and "The Reliability and Validity of Kiddie-Schedule for Affective Disorders and Schizophrenia-Present and Lifetime Version-Korean version" (2004). The second phase focused on epidemiologic studies, including "Psychiatric morbidity of second and third grade primary school children in Korea (2006)," "Psychiatric comorbidity assessed in Korean children and adolescents who screen positive for Internet addiction (2006)," and "Temperament and character among Korean children and adolescents with anxiety disorders (2009)." The third phase focused on phenomenological studies, including "Temperament and character among Korean children and adolescents with anxiety disorders (2009)," and "A 6-month follow-up study of posttraumatic stress and anxiety/depressive symptoms in Korean children after direct or indirect exposure to a single incident of trauma (2009)."

The fourth phase focused on biochemical studies, including "Study on the Relationship between ontogenetic processes of Neurotransmitter System and Psychopathology in ADHD (2001)," "Phthalates exposure and ADHD disorder in school-age children (2009)," and "Co-exposure to environmental lead and manganese affects the intelligence of school-aged children (2009)." The fifth phase focused on brain imaging research. The following papers belonged to this category: 1) "Regional cerebral perfusion abnormalities in ADHD (2002)," 2) "The segmented regional volume of the cerebrum and cerebellum in boys with Tourette Syndrome (2002)," 3) "Regional cerebral perfusion abnormalities in developmental language disorder. Statistical parametric mapping analysis (2006)," 4) "Relationship between N-acetyl-aspartate in gray and white matter of abstinent methamphetamine abusers and their history of drug abuse: a proton magnetic resonance spectroscopy study (2007)," and 5) "Relative areas and white matter integrity of corpus callosum in drug-naïve attention deficit hyperactivity disorder: subregional volumetry and fractional anisotropy values by 3-dimensional magnetic resonance and diffusion tensor image (2008)". The sixth phase included genetic studies: 1) "No association found between 130 Val/Met polymorphism of the COMT gene and schizophrenia with minor physical anomalies (2005)," 2) "Positive association between Tourette's disorder and Catechol-O-methyl transferase gene in Korean subjects (2005)," 3) "The homozygosity for 10-repeat allele at dopamine transporter gene and dopamine transporter density in Korean children with attention deficit hyperactivity disorder: relating to treatment response to methylphenidate (2005)," 4) "Clinical and genetic characteristics of Korean male alcoholics with and without ADHD (2006)," 5) "Serum homocysteine folate level and methylenetetrahydrofolate reductase 677, 1298 gene polymorphism in Korean schizophrenic patients (2006)," 6) "Association of the DAT1 polymorphism with ADHD: a family based approach (2006)," 7) "Possible association of the alpha-2A-adrenergic receptor gene with response time variability in attention deficit hyperactivity disorder (2008)," 8) "No evidence of an association between the norepinephrine transporter gene polymorphisms with attention deficit hyperactivity disorder: family-based and case-control association studies in a Korean sample (2008)"



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(cont'd 1)

9) "No evidence of an association between the norepinephrine transporter gene polymorphisms with attention deficit hyperactivity disorder: family-based and case-control association studies in a Korean sample (2008)," 10) "Association between the alpha-2C-adrenergic receptor gene and attention deficit hyperactivity disorder in a Korean sample (2008)," 11) "Association between PTGS2 polymorphism and autism spectrum disorders in Korean trios (2008)," 12) "Shorter dinucleotide repeat length in the DRD5 gene is associated with attention deficit hyperactivity disorder (2009)," 13) "Family-based association study between NOS-I and -IIA polymorphisms and autism spectrum disorders in Korean trios (2009)," 14) "Copy number variations associated with idiopathic autism identified by whole-genome microarray-based comparative genomic hybridization (2009)," and 15) "Family-based association study of microsatellites in the 5' flanking region of AVPR1A with autism spectrum disorder in the Korean population (2010)." The seventh phase included research on pharmacotherapy: 1) "Neuroleptic malignant syndrome due to three atypical antipsychotics in a Korean child (2005)," 2) "Effectiveness and Safety of Risperidone for Children and Adolescents with Chronic Tic or Tourette Disorders in Korea (2005)," 3) The relationship between regional cerebral blood flow and response to methylphenidate in children with attention deficit hyperactivity disorder: comparison between nonresponder to methylphenidate and responders (2007)," 4) Long-term sustained benefits of clozapine treatment in refractory early onset schizophrenia: A retrospective study in Korean children and adolescents (2009)," 5) "Neurocognitive effects of switching from methylphenidate-IR to OROS-methylphenidate in children with ADHD (2009)," and 6) "The effect of OROS methylphenidate on the sleep of children with attention-deficit/hyperactivity disorder (2010)."

The eighth phase included integrative studies on relationships between genetic polymorphisms, brain imaging findings, and/or drug responses: 1) "Regional Cerebral Blood Flow in Children with Attention Deficit Hyperactivity Disorder: Comparison Before and After Methylphenidate Treatment (2005)," 2) "The Relationship between Regional Cerebral Blood Flow and Responses to Methylphenidate in Children with ADHD: Comparison between Non-responders to Methylphenidate and Responders (2007)," 3) "Association of 4-repeat Allele of the Dopamine D4 Receptor Gene Exon III Polymorphism and response to Methylphenidate Treatment in Korean ADHD Children (2006)," 3) Possible association of NE transporter-3081(A/T) polymorphism with methylphenidate response in ADHD (2010)," 4) "Val/val genotype of brain-derived neurotrophic factor(BDNF)Val Met polymorphism is associated with a better response to OROS_MPH in Korean ADHD children (2011)."

The ninth and last phase included research on spiritual issues: 1) "Beethoven- His Life and Music. Developmental Perspective (1997)," 2) "Study on the positive power in interpersonal relationship (1998)," 3) "The meaning of absoluteness and introspection (1996)," 4) "Study on the introspection in interpersonal relationship (2000)," 5) Principles of power, control and survival in interpersonal relationship (2000)," 6) "Morality and Survival (1996)," 7) "Music and Psychiatry (2001)," 8) "Water and Introspection," 9) "Water as the ideal model for Bio-Psycho-Socio-Spiritual Model (2005)," 10) "Beethoven's late string quartets. the relationship between musical expression and personality development (1997)," 11) "Hermann Hesse - His work and musical thinking (2010)," and 12) "Development of Mindfulness Program (2010)."

This self-reflection showed the developmental phases of my research in my whole career as a professor. The nine phases can be clustered into three main stages. The initial, preliminary, stage involved reliability and validity studies on various assessment instruments. The subsequent stage involved research on diseases: epidemiological studies, phenomenological studies, biochemical studies, brain imaging studies, pharmacotherapeutic studies, genetic studies, and integrative studies.



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The last stage involved research on the whole person and included research on cognitive-behavior therapy for children, parents, and teachers; the relationship between music, literature and psychiatry; the symbolic meaning of water; the meaning of absoluteness and introspection; the relationship between introspection and interpersonal relationships; and the relationship between morality and social survival. In a similar vein, when I look back at the developmental processes in the specialty of psychiatry, I also find three definite developmental processes. I would call the initial stage as the stage of consilience or integration. In Hippocratic thinking, every contrasting two things are integrated into one concept: human vs. nature, medicine vs. humanities, naturalism vs. humanism, medicine vs. philosophy, mysticism vs. rationalism, open education vs. closed education, and part vs. whole. Ancient Oriental medical books emphasize Taoism in caring for patients. Tao means treating the patient as a whole person based on the bio-psycho-socio-spiritual concept. The core concept of Daedejing of Laozi is the "Thought of Getting One from Two Contrasts," and similarly, the core concept of Changtzu is that "There is no discrimination in everything." In Buddhism, the core concept is the "Thought of Non-Two." All of these concepts from Greek and Oriental books are just different expressions of the same concept, namely "consilience." Recently, this term has been very popularly used across various academic fields. The literal meaning of "consilience" is "to jump together." William Whewell and Edward Wilson first used this term to describe the unity of knowledge. Currently, "consilience" is defined as unifying every field of knowledge and science to understand the human being and improve human life. The second stage is the period of diversity or period of reductionism, meaning that the whole concept is reduced into a specific field. During this period, many kinds of reduced schools began to appear: schools of biology, schools of consciousness, schools of psychology, schools of interpersonal relationship, schools of sociology, schools of phenomenology, and schools of cognitive-behavioral psychology.

The third stage is the stage of re-consilience. Engel proposed the bio-psycho-social model based on general systems theory. The World Health Organization (WHO) maintains a similar model: in defining a human being's health, WHO proposes three basic components, which are physical well-being, psychological well-being and social well-being. In 1999, the members of WHO had hot discussions on whether or not spiritual well-being should be included in the definition of human health. At the end of the discussions, they excluded spiritual well-being. I believe that spiritual well-being should be included in our understanding of the human being, because the spirit is the main focus of religion, literature, art, and philosophy – all of which cannot be completely separated from the whole person. The DSM-IV and DSM-V, have included religious problems, two of which are loss or questioning of faith and conversion to a new faith. In childhood and adolescence, culturally shaped parental expectations of child behavior are influenced by the spiritual perspectives of faith traditions and communicated through family relationship. There is an inverse relationship between religious involvement and depression and suicide. Parental religiousness may lower rates of child depression, while lower church attendance may increase rates of depression. Family relationship factors that predispose to conduct disorder are influenced by cultural factors, including parents' spirituality. The early onset of risk behaviors such as sexual behaviors, drinking, and illicit substance use is strongly affected by family spiritual precepts. All of these findings suggest that spiritual and religious issues should be included in our profession's understanding of the human being as a whole person.

When I look back on my development over 30 years as a researcher in child psychiatry, I have tried to understand the human being as a whole person, including bio-psycho-socio-spiritual aspects beyond specific disorder. Thus, the concept of 'consilience' can be applied to my own research experience.



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CAP Section Officers meet Professor Dinesh Bhugra, the incoming President of the World Psychiatric Association



Gordana Milavić, (Co-Chair WPA CAP, UK)

Professor Bhugra offered a warm welcome to Prof. Leventhal and Dr Milavić. He described his vision of services for the mentally ill, a strategy underpinned by a combined social and medical approach to all psychological illness and a focus on public and community psychiatry. More specifically, and of the greatest relevance to the WPA CAP Section, Professor Bhugra is planning to address mental illness in children and young people. He recognizes that three quarters of psychiatric disorders occur between the ages of 15 and 24 and that primary and secondary prevention have to start early in families, schools, GP surgeries and social care establishments. Following a productive discussion with Professor Bhugra, Professor Leventhal and Dr Milavić outlined the strategy for the work of the CAP Section over the next four years.

1. It was agreed that the WPA CAP section will assist the incoming WPA President by promoting the child and adolescent mental health agenda within WPA and on an international level through its policies and action plans. One of the WPA CAP Section's priorities is to raise the profile of CAP activities at WPA meetings by offering a larger platform to CAP symposia and workshops and by inviting CAP clinical and research experts to present plenary sessions and keynote lectures. It was pointed out that the CAP Section has already submitted a large number of CAP symposia and presentations for the forthcoming WPA World Congress in Madrid in September 2014.
2. In raising the profile of the WPA CAP section within the WPA it was suggested that CAP members take a leading role in cross sectional activities.
3. It was proposed that there should be an emphasis on 'developmental psychopathology', which should become the common thread throughout psychiatric training and mental health services planning. Developmental psychopathology principles of psychiatric training and care will represent one of WPA and WPA CAP Section central tenants.
4. A great deal of the discussion focused on the relationships between other child and adolescent organizations across the world and the need to unite the sometimes fragmented activities of these organizations by establishing common aims and programmes. As an example of a beginning of such a collaboration Professor Bhugra has agreed to establish links with the current president of the American Association of Child and Adolescent Psychiatry (AACAP), Paramjit Joshi. Although an "American" organization, AACAP probably has the highest level of international participation of any child psychiatry organisation.
5. "The World Child and Adolescent Psychiatry" journal, published by the WPA CAP Section has gained a worldwide audience. Equally all efforts will be made to contribute to the WPA Newsletter and journal.

This meeting, it was agreed, was the beginning of a closer collaboration between the WPA CAP and the WPA. The WPA CAP Section, led by its officers, looks forward to putting its action plans into practice, building a stronger and greater role for child and adolescent psychiatry in the WPA and strengthening the network of child mental health professionals across the world.



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Editor's note: We are pleased to feature this important contribution from Drs. Keren, Guedeney, and Tyano. We commend the World Association for Infant Mental Health (WAIMH) for their efforts in prevention and early intervention, which are clearly essential to meeting the need for global child, adolescent, and adult mental health in the face of limited resources.

Becoming a parent is a major stressful event for vulnerable adults: The need for an integrated management of parent and infant mental health

Dr. M. Keren, Prof. A. Guedeney, and Prof. S. Tyano (WAIMH)

Transition to parenthood is a major stressful life-event (Guedeney & Tereno, 2010). Parenting is, in its essence, the domain where adult mental health and infant mental and physical health meet in a complex and dynamic interplay. Being a 'good-enough' parent is indeed a universal challenge and is even more so for mentally vulnerable individuals. Doing so involves the parent's capacity to gratify as well as to frustrate one's child in an age-appropriate balanced way, and most importantly to repair inevitable mismatches in the interaction with the infant, thus reaching a good enough level of synchronisation. Indeed, the younger the infant, the easier he or she may be disorganized with a violation of synchrony within the parent-infant relationship (Tronick, 1978). Becoming a parent often exacerbates an existing mental illness, and in turn, maladaptive parenting impinges on the early parent-infant relationship and on the infant's socio-emotional development and later functioning. Pregnancy and the year after giving birth are a time where a woman is most at risk of increased mental symptomatology through either triggering of latent vulnerability or exacerbation of existing psychopathology (Olsen et al, 2006). The impact of stress in pregnancy on the fetus, the infant, and the child has been well shown in animal as well as in human studies (Keren, 2010).

The parental capacity for mentalization as a bridging concept between adult and infant psychiatry:

Mentalization is defined as the process of interpreting one's own and others' behaviours in terms of mental and emotional states (Fonagy et al, 2002). Dysfunctional and traumatic early attachment relationships due to neglect; abuse; and dissociative, highly intrusive, and/or grossly unpredictable patterns of parental responses have long term detrimental and disruptive effects on one's later capacity to use his/her innate competence for mentalization and to adequately deal with the challenges embedded in intimate and affiliative relationships (Bateman et al, 2000). The quality of the family environment has a major role in the development of mentalization: the frequency of perspective taking in caregiver-child verbal interactions (Hugues & de Rosnay, 2006), the amount of role play in the family, and the degree of family verbalization of conflicting emotions (Cutting & Dunn, 1999) have been found as correlates of mentalization capacity in parents as well as in children. When the individual becomes a parent, his/her own capacities for mentalization, i.e. the readiness to understand his/her baby's behaviours in terms of mental states, will set the stage for the development of mentalization in the young child. Macfie et al (2009) showed, among 30 children aged 4-7 years whose mothers have BPD as compared with 30 normative dyads, significantly different representations of caregiver-child relationship and of the self, as reflected in story-stem completion task. The offsprings of mothers with borderline personality told stories with more parent-child role reversal, more fear of abandonment, more negative mother-child and father-child relationship expectations, more shameful representations of the self, poorer emotion regulation with confused boundaries between fantasy and reality, and less narrative coherence. Maternal identity disturbance and self-harm were the most potent predictors of these maladaptive self and caregiver-child relationship representations among the children of mothers with BPD.



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The impact of parental psychopathologies on the infant:

Parental psychopathology, regardless of the specific diagnosis, impinges on the child's socio-emotional development through the impact of impaired parenting behaviors, regardless of the specific parental psychiatric diagnosis (Rutter & Quinton, 1984). It is not the diagnosis, but the parent's behaviors that interfere early and directly with the child's developmental tasks and needs such as regulation of behaviors and affects, basic sense of security, balanced autonomy and dependency, and the development of a positive view of self and others. Repeated parent's hospitalization is especially difficult for offspring's between 6 months and 5 years. Dickstein (1998) emphasized the role of family functioning, as she found it to be the most powerful mediator of parental mental illness' impact on a child. In addition, it is the number of risk factors in the infant, the parent, and their environment that is more predictive of offspring's psychopathology rather than the nature of the risk factors (Sameroff, 2000). For instance, some parenting behaviors such as hostility are detrimental for all ages, but sadness is especially problematic for young children (Field, 1995). Mothers with depressed mood touch their infants more negatively and talk to them in a way that is less well adjusted to their infant's developmental needs (Murray & Cooper, 1997). Three different patterns of depressed mothers' interactions with their infant, with decreasing order of impact on the infant have been identified (Cohn et al, 1986): disengaged and apathetic; engaged, but angry and intrusive; and engaged and positive. It is the consistency and pervasiveness of messages across interrelated contexts of the family relationship, the maternal specific behaviors related to her depression, and the characteristics of her interaction with the child, that increase the child's vulnerability. Radke-Yarrow's 15 year longitudinal study (1985) has shown that there is no universal outcome of children early exposed to maternal depression, as each case is the result of the interplay between vulnerability and resilience factors in child and parents; and that overall growing up as a child of a depressed parent is costly, as many parents may have serious and multiple diagnoses, not only depression. As will be illustrated in the following vignette, it is not enough to treat the mother's depressive symptomatology. We must also address, **as early as possible**, the maladaptive mother-infant **interactive** patterns, the specific mother's "depressive" **attitudes** conveyed to child, the **other parent's** functioning, and the proximal **support** system.

H., 32 years old, and her 3 months-old baby boy, was referred to our (MK) Infant Mental Health Unit with suspected postpartum depression. Baby's birth was complicated with hemorrhagic enterocolitis of unknown origin, which had necessitated a two-month hospitalization. At the hospital, mother's sadness was thought to be secondary to her baby's condition; therefore the medical staff did not send her for a psychiatric consultation. She was seen by her general practitioner, who prescribed her an antidepressant. Still, her husband was very concerned, and asked the Well Baby Community Nurse to refer them to a child psychiatrist. He was actually hoping to avoid the error they made 5 years before, when she developed postpartum depression following their first child's birth and did not ask for treatment. Their daughter developed into a very dependent child, with poor peer-relationships, and they were both aware of the link between their daughter's difficulties and her long lasting depression. When we saw them as a triad, she indeed had no interaction with the infant, and father was the main caregiver. Baby already exhibited gaze avoidance towards his mother. She admitted to having aggressive impulses towards the baby, and therefore was afraid of staying alone with him. Her mother came and stayed with her while her husband was at work. On one hand, this arrangement was safer for the baby; on the other hand, it reinforced her avoidance towards him and worsened her ambivalent relationship with her dominant and intrusive own mother.



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We installed a treatment plan that included mother-father-baby psychotherapy and individual psychotherapy (in addition to the medication) for the mother, and a significant improvement in the mother-infant interaction was achieved within 4 months. The triadic sessions went on for a year and half, but individual psychotherapy is still ongoing.

The challenging task of parenting, which involves the provision of a safe environment for the infant, attendance to physical needs, appropriate age-related stimulation, and the establishment of an attuned and secure relationship, can be very much affected by a new-onset postnatal psychosis, as well as by a long-standing illness, such as schizophrenia, bipolar illness, or substance abuse. A psychotic mother who perceives her baby as a dangerous, ill-intentioned creature, may become dangerous to him/her or may withdraw from caregiving tasks. In these situations, the main therapeutic challenge is to ensure the baby's physical and emotional safety, and in parallel, to try to keep some continuity of contact between the mother and the baby, so that if and when she feels better and comes back home, both she and the infant will not be strangers to one another.

Surprisingly, little attention has been given to the impact of parental OCD on the quality of parenting. An incidence of 4% among 302 women who developed post-partum OCD (PPOCD) at 6 weeks has been reported (Uguz et al, 2007; Zambaldi et al, 2009). Still, the literature about the psycho-social development of these mothers with postpartum OCD is practically inexistent. In our clinical experience at a community infant mental health unit, we have come to know that the entry into parenthood often exacerbates an already existing OCD, and parenting make it worse, up to the point of evoking aggressive feelings towards the baby who is perceived as preventing the mother from performing her rituals. We have had in the last five years some 15 cases of infants born to mothers with OCD. None of them have developed childhood OCD, at least in their first four years of life, but all of them have oppositional behavioural traits mixed with anxious features.

S., two years old, was referred to us by her paediatrician because of sleep problems and overeating, with no organic cause. She was the first child of a couple in their thirties. Mother suffered from OCD since her early twenties but was never treated. She did have psychotherapy for her difficulty to engage into intimate relationships with men. When she was pregnant, she became obsessed with the doubt of being able to love her future baby. Right after birth, she felt she did not love her "enough".

We will end with a clinical vignette that illustrates the combined impact of maternal depression and personality disorder, with unresolved past loss, on the parenting of an infant with slow-to-warm-up temperament.

S., a two-month old baby girl and her mother, A., were referred to our Infant Mental Health unit by a community nurse for a suspected post partum depression. "Even breast-feeding does not calm her. I'm really bad at it, she knows it." Standard questions about the course of the pregnancy and delivery triggered the mother to tell about her pathological grief over her only sister's killing in a car accident 10 years before. Having dreamt about her late sister, A. felt she had to "get pregnant and have a girl like her sister," in spite of her inner feeling that she was not ready for motherhood.



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Baby's name was identical to her late "little aunt's," except for one letter. A. linked her lack of readiness for motherhood to her own history of growing up with a drug-addicted and sexually promiscuous mother, and of having experienced sexual abuse by her stepfather. During the mother-baby sessions, maternal pathological projections on the infant were identified: S. was born in order to continue A.'s late sister's existence (a "replacement" child), and her cry reminded A. of her sister's clingy behavior. As a result, A. had an in adaptive reaction to S.'s normative cry: she would either gratify the child at once, or she would become harsh and rejecting. S. reacted by either becoming very irritable, or by having over-compliant behavior, at the price of her exploratory behavior.

It became evident how A.'s projections on S. impinged on her ability to be a consistent protective figure for the child. Following a session where she talked about the car accident and her guilt feelings, a frightening "missed" accident happened to S.: A. "forgot" to tie the baby in her stroller. Her ability to put limits on the infant was also very poor, because saying "no" reminded her saying "no" to the sister just before the crash accident. An additional distorted parenting behavior was around sleep habits: S. slept with the mother because, in A.'s perception, "nights are dangerous to sleep alone" (A. unconsciously perceived her husband as potentially harmful to her and her child). S's father had a less dramatic childhood history, but his attachment experiences were very negative with a history of physical abuse by his mother and a helpless father. His psychological functioning was one of someone with a narcissistic personality disorder, and, unlike his wife, he had absolutely no insight into his own problematic parenting behaviors. The marital relationship became very tense and ended with separation.

This clinical case illustrates how very early traumatic attachment experiences lead to a basic and pervasive lack of trust and unstable close relationships (so characteristic of adults with borderline personality disorders) and are transmitted from one generation to another, as entry into parenthood triggers distorted projections on the infant, who then becomes dysfunctional (Conroy et al, 2010).

Conclusion:

Early detection of these high risk families is crucial if one were to try to prevent the development of personality disorders, and should be achievable by adult as well as child psychiatrists. In spite of this important principle, fragmentation of the disciplines is still very common: adult psychiatrists treat individuals, with no specific focus on the parental self. In this paper, we aim at proposing an integrated model for joint assessment and treatment of the ill parent and the infant.



Is it possible to conduct collaborative multisite CAP research without funding and without physical contact among collaborators? The International Child Mental Health Study Group (ICMH-SG) experience

Dr. Franic Tomislav (Croatia), Dr. Olayinka Atilola (Nigeria), Dr. Stevanovic Dejan (Serbia)

In the beginning

Child psychiatrists (to the degree that they exist) in developing countries are primarily clinicians, with little or no training in child and adolescent psychiatry (CAP) research. But as much as they may want to prioritize the clinical aspects of their work, the effectiveness of anything they do is inevitably limited by a paucity of data on the numbers, features, and proportions of the disorders that they seek to treat. Lack of such data hampers systems-level planning and strategic policy formulation. Lack of relevant data on CAP in developing countries is a result of a severe shortage of personnel, funding, and publication bias as has been observed in the case of general adult psychiatry (Helal et al., 2011). As a consequence, CAP policy and services in developing countries is often driven by extrapolations from data generated from developed countries without considering cross-cultural differences.

Motivated by a need to contribute our widow's mite to bridging gaps in CAP research in developing and undeveloped countries, the ICMH-SG was formed during the 2nd Excellence in Child Mental Health Conference, which was held in Istanbul, Turkey in November 2011. We took advantage of the developing country fellowship that brought together young and talented CAP practitioners from different parts of the world, under the mentorship of Prof. Panos Vostanis of the School of Psychology, Leicester University, United Kingdom. The foundation members were Olayinka Atilola (Nigeria), Dejan Stevanovic (Serbia), Yatan Pal Singh Balhara (India), and Mohamad Avicenna (Indonesia). Since its inception in Nov 2011, active membership has grown to involve members from at least 15 developing countries.

The aims and purpose of the ICMH-SG

The ICMH-SG has evolved into a non-profit research-oriented organization of child and adolescent psychiatrists, psychologists, and other mental health practitioners from developing countries. The group aims to improve the quality of evidence-based child and adolescent mental health (CAMH) services in developing countries through the following activities, with an emphasis on cross-cultural differences and similarities:

- a) Organizing research projects and promoting excellence in CAMH research;
- b) Organizing projects aimed at improving evidence-based clinical and community-based CAMH services;
- c) Organizing and/or supporting the development of public health policies relevant to CAMH;
- d) Disseminating information about CAMH in undeveloped and developing countries through journals, books, newsletters, blogs, and other means of communication;
- e) Contributing to initiatives aimed at improving ethical standards in CAMH services and research;
- f) Disseminating information through journals and books;
- g) Collaborating with and/or participating in the activities of other national and international CAMH and allied organizations; and
- h) Organizing other activities that directly impact on CAMH development in developing countries.



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Dr. Franic Tomislav (Croatia), Dr. Olayinka Atilola (Nigeria), Dr. Stevanovic Dejan (Serbia)

Funding and tools of collaboration:

We are not oblivious to the reality that CAP research is currently not a global funding priority. So we decided to make marmalade in the absence of lemon. We took advantage of the richness of the virtual world of online communication, the depth of our personal social network, and the extensive lessons from the well described strength of social capital (Sartorius, 2002). Using these invaluable assets, we succeeded in organizing our first collaborative cross-cultural CAP research project without any external funding or further in-person contact with the members. In fact, we have yet to meet some of the collaborators in-person!

Past and ongoing projects:

We have concluded the first project, titled "Quality of life (QOL) and substance use disorders (SUD) among adolescents in undeveloped and developing countries." This project has produced a number of publications (Atilola et al, 2013; Stevanovic et al, 2013; Stevanovic et al, in press; Atilola et al, in press; Stevanovic et al, in submission).

In November 2013 we commenced a second project, titled "Recent trauma and life stress events as related to major psychological problems among adolescents: the ICMH study-group initiative." This project, coordinated by Olayinka Atilola and Dejan Stevanovic, aims to assess possible relationships between traumatic events and emotional problems in adolescents sampled from predominantly developing countries. The project has attracted more than 18 young researchers from 11 countries and is nearing the data collection stage.

Without wanting to sound immodest, the ICMH-SG experience has shown that there is a niche for a group like ours in the global quest for advancing and expanding CAP research and services development.

More information about the ICMH-SG is available at:

<https://www.facebook.com/pages/International-Child-Mental-Health-Study-Group/423569974422042>

<https://www.facebook.com/groups/studyicmh/?fref=ts>

<https://sites.google.com/site/icmhgroup/>



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Serving the Libyan refugees in Tunisia: a Psychiatrist's Experience

Dr. Tawfik Masaud (Ireland\Libya)

Introduction:

Disasters, including man-made ones, can cause significant acute and chronic psychiatric symptoms and disorders, the assessment, management, and prevention of which are the scope of disaster psychiatry. The 2011 crisis in Libya prompted the exodus of thousands into a vast geographic area of neighbouring countries, especially Tunisia. As many adult men stayed back to defend cities, most of the refugees were women, children and the elderly. While there were three designated refugee camps, the majority stayed in villages and towns outside the camps.

There was a significant need to provide health care for the displaced people. Psychiatric services were almost non-existent in the Libyan western mountains, from where the majority of refugees came, and psychiatric services in south Tunisia, where the majority of refugees settled, could barely accommodate local needs. The influx of thousands of Libyan refugees overwhelmed the local services, and there was therefore an urgent need to meet the new healthcare demands.

Objectives:

This paper aimed to describe the experience of a volunteer psychiatrist in the refugee camps and to provide recommendations for the future.

Methods:

The author, from a network of volunteer Libyan doctors from inside and outside of Libya, worked to provide mental health care to the Libyan refugees from last week of May 2011 through the first two weeks of June 2011. As this paper was focused on personal reflections rather than a systematic collection of information involving human subjects, ethical approval was not pursued.

Results and Discussion:

There were a number of volunteer medical organisations working in the refugee camps, including "Doctors Across Continents" and groups of Libyan doctors from inside and outside Libya. The groups were initially working independently; however, their efforts were later coordinated, and a joint committee was formed. Each evening, a meeting was held that enabled discussion of cases that needed follow up or specialists' input.

The volunteer Libyan doctors from abroad were recruited mostly through an overseas Libyan health professionals' network that formed shortly after the start of the revolution in Libya. The group was coordinated largely through emails and Paltalk (online) meetings. The group grew from a few hundred to over a thousand volunteers.

In order to provide disaster relief and healthcare services, the health professionals and relief workers conducted regular convoys to the refugee camps and the remote villages. The author joined medical convoys that provided care to the three refugee camps and the widely dispersed villages. Over a three week period, the author also ran twice weekly clinics in the centre of Tataween, the main town in south Tunisia, very close to the Libyan border.



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Dr. Tawfik Masaoud (Ireland\Libya)

Medications were supplied partly by the Benghazi medical group, by Tunisian psychiatrists, and by the local hospital in Tataween. Using donated charitable funds, two volunteer pharmacists procured and organised the delivery and dispensing of medications.

Services were provided to male and female child, adult, and elderly patients. In Libya, there is a high stigma with social implications of mental illness, and as a result, people may forego seeing the psychiatrist. Also, in the author's experience, a common explanatory model for mental illness is that it is caused by an "evil eye" from an envious person or by possession by a jinn (evil spirit) brought about by black magic practiced by an envious person or an enemy.

Other relevant barriers to psychiatric care included a perception, particularly among Libyan men, that admitting psychological suffering is a sign of weakness. There also may be discomfort with receiving psychiatric care at the refugee camps, where there is less privacy and where people, often originating from the same part of Libya and staying close in the camps, are more likely to know each other.

In the face of these barriers, we found it particularly effective to deploy same-gender social workers, psychologists, and other health professionals to help identify and bring patients for treatment.

Services were provided for acute, trauma-related conditions as well as for potentially pre-migration conditions that may not have been addressed due to either stigma or unavailability of psychiatric care. Medications prescribed included; antidepressants, (e.g., tricyclic antidepressants such as clomipramine and serotonin-selective re-uptake inhibitors such as fluoxetine, sertraline and citalopram); antipsychotics such as haloperidol, olanzapine, and risperidone; and anticholinergics such as benhexol. The older generation antipsychotics and tricyclic antidepressants were relatively cheap and easy to procure; however, their use was associated with difficulties in terms of side effect profile (e.g., extrapyramidal side effects from older neuroleptic medications) and complexity of dose titration. Benhexol, needed to address extrapyramidal side effects, was difficult to obtain because of high abuse potential.

Follow up was a challenge because of the short duration of the author's stay and the very wide geographical distribution of the refugees. Telephone call follow up was helpful in some cases where face-to-face follow up was not feasible.

Conclusions & Recommendations:

Psychiatrists must be prepared to treat patients when disasters occur. There is an urgent need for ongoing psychiatric services to assess and manage new patients and to follow up those who need continuing care. Having a regularly scheduled clinic in a centrally located, accessible location is likely to increase patients' utilization of services. Psychiatrists from other cultures should be aware of stigma and alternate explanatory models for mental illness.



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Trainee Corners

Editor's note: It is my pleasure to announce the commencement of trainee corner in this journal, edited by Dr. Tomoya Hirota. In this corner, we feature various informative and locally and internationally prominent topics in child and adolescent psychiatry. Much appreciation for the contribution from Dr. Bershader to the introduction and overview of adolescent substance use.



Dr. Robin Bershader (USA)



Dr. Tomoya Hirota (Japan\USA)

Algebra to Addiction: An Overview of Adolescent Substance Abuse in the United States

Drug and alcohol use among American adolescents is assessed annually through Monitoring the Future (MTF) surveys, which document national substance use and perspectives among 8th, 10th, and 12th graders. The National Institute of Drug Addiction (NIDA), a branch of the National Institute of Health (NIH), helps fund this assessment, which surveys 40,000-50,000 students each year. In general, alcohol and cigarette use have decreased while cannabis use has increased. Results from the 1997 survey mark the highest lifetime prevalence of alcohol and cannabis use at 68.2% and 35.8% respectively.

Alcohol has shown a steady drop, with a 2013 prevalence of 48.2% (-1.6% since 2012). Tobacco use has decreased from 57.8% in 1996 to 25.6% in 2013 (-1.4% since 2012). Narcotic use, other than heroin, decreased 1.1% since 2012, making the lifetime prevalence among 12th graders 11.1% (data not available for other grades). Cannabis, however, has been creeping upwards since 2009 with a current lifetime prevalence of use at 32% (+1.3% from 2012).

There are numerous sociopolitical factors - , including the dynamic and state dependent, legalization of marijuana taxation of tobacco products, and accessibility to alcohol that impact upon these trends.



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Trainees Corner (cont'd)

Dr. Robin Bershader (USA)

The consequences of addiction on the kin of those affected has resulted in a cycle of maladaptive behaviors and parenting techniques. During high school I was fascinated by the disparity between acceptable substance experimentation and detrimental dependence. The primary determinant of outcome seemed to be school performance, as it was perceived to reflect lifetime trajectory.

During college I learned about the use of psychoactive substances cross-culturally, such as the use of Peyote in annual regeneration ceremonies among the Huichol Indians of Northern Mexico. Addiction was no longer an abstract concept, but an entrenched cultural, medical, and socioeconomic detriment grounded in the basic human desire for experiential excitement. Medical school provided me the opportunity to visualize the spectrum of American substance abuse. Through rotations in pediatrics, obstetrics, medicine, surgery, and psychiatry, I saw the vast consequences of addiction on non-users and users alike. Whether it was pain treatment gone awry, experimentation with lifestyle entrenchment, self-medication reflective of social strain, or failure of the mental health system; drug and alcohol dependence has the voracious ability to consume and destroy lives. I have found that many in the medical community feel we can treat the medical complications of addiction though are powerless in stopping the cycling through generations.

I, however, strongly disagree. Addiction is biologically and psychologically transferred from one generation to the next; thus, if we help young adults struggling with addiction to alter their behaviors and substance use, we are also impacting the lives of their future children. Working with adolescents in the rehabilitation setting was an experience I found particularly intriguing as the patients tended to have less severe economic and legal baggage related to their substance use. The opportunities available to adolescents can be used as a major tool to encourage career focus, social development, and future family planning. Addiction and adolescent psychiatry bridge two arenas I find fascinating, as the development occurring neurobiologically and psychologically is delicately malleable. The environment in which I plan to practice is changing as I journey through my general psychiatry residency training. Public health involvement and school program development are areas in which I feel adolescent addiction can be addressed; however, with the national shortage of psychiatrists, especially child and adolescent psychiatrists, the ability to generate large scale change is quite an obstacle.

Though the decrease in alcohol and tobacco use is encouraging, the variable legal and social discourse regarding taxation, marijuana, and alcohol create ambiguity among America's youth that should be taken into consideration as we work towards educating the next generation. Continuing to focus on productivity as a nation and individual achievement can encourage adolescents to achieve their goals without allowing substance use to interfere with their dreams.



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Interview with Professor Jane Foy

1. Thank you very much for agreeing to this interview. It's truly our pleasure and our privilege to have you as part of this issue of World CAP. Would you be able to tell us a little bit more about yourself and the important work you have done in promoting mental health in the medical home?

I am a general pediatrician, currently Professor of Pediatrics at Wake Forest University School of Medicine. For many years prior to joining the Wake Forest faculty, I served as medical director of a community pediatric clinic that provided care to low-income children, many of them experiencing chronic medical conditions complicated by mental health problems. We formed teams of physicians, nurse practitioners, nurses, and social workers who collaborated in the comprehensive care of these patients and their families. We also held a weekly conference with a community psychiatrist and a developmental pediatrician to discuss those with the most challenging behavioral health problems. These were formative experiences, convincing me that multi-disciplinary primary care practice is not only feasible and satisfying, but necessary.

In 1998 I became president of the North Carolina Chapter of the American Academy of Pediatrics (AAP). In that role I had the opportunity to work with fellow pediatricians who recognized the importance of behavioral health care to our patients and their families. We set out to improve access to behavioral health services for the state's Medicaid recipients and enhance coordination of their primary health care and behavioral health services. To that end we formed a task force with colleagues from child psychiatry, psychology, and social work and successfully advocated for changes in NC Medicaid policies to allow children up to 26 annual unmanaged behavioral health visits to primary care physicians or mental health specialists, 6 without a diagnosis; and credentialing of behavioral health professionals working in settings outside the public behavioral health system. These changes made possible new patterns of collaboration between primary care clinicians and behavioral health professionals, including co-location and integration of behavioral health professionals in primary care settings. In the years since, I have worked to implement these integrated models in NC.

When the AAP decided in 2004 to make mental health one of its top priorities, it formed the Task Force on Mental Health, which I chaired. [The AAP defined "mental health" as encompassing the full range of psychosocial and substance use issues.] Task Force members included representatives from the American Academy of Child and Adolescent Psychiatry (AACAP), as well as other mental health professional associations and advocacy organizations. We were charged with assisting primary care clinicians to enhance the mental health care they provide to children. The Task Force began with the assumption that there is a "primary care advantage" that primary care clinicians enjoy as providers of mental health services—including a longitudinal relationship with children and families, experience providing family-centered care to children with chronic conditions, and expertise in collaborating with specialists. The Task Force joined with AACAP to publish an article offering guidance on addressing administrative and financial barriers to providing mental health services in pediatric primary care settings [Pediatrics, Vol. 123, No. 4, April 2009]. Subsequent publications articulated the mental health competencies necessary for primary care practice [Pediatrics, Vol. 124, No. 1, July, 2009] and proposed processes by which pediatricians can enhance their own mental health practice, the mental health resources and systems in their communities, and the effectiveness of their collaboration with mental health professionals [Pediatrics, Vol. 125, June, 2010].



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Interview with Professor Jane Foy (cont'd 1)

The Task Force also produced a toolkit to assist with these enhancements. Since the final Task Force publication in 2010, I have served on the AAP Mental Health Leadership Work Group, which aims to further the work of the Task Force.

2. How do you envision collaboration between pediatrics and psychiatry in the healthcare world of the future?

Because of the relatively small number of child psychiatrists, I think child psychiatrists will increasingly focus their direct clinical services on children with severe and persistent mental illness (SPMI). Some psychiatrists will work within organizations that form “health homes” for these children, adding a primary care clinician (often a nurse practitioner or physician’s assistant) to their staff in an effort to address unmet preventive and medical care needs of those patients who do not (or cannot) access a primary care medical home. Such arrangements will be most successful if the embedded mid-level primary care clinician has a connection with (or employment arrangement within) a pediatric primary care medical home that includes the expertise of a pediatrician to oversee care of children with co-morbid chronic medical conditions and to facilitate access to and coordination with medical subspecialists, 24/7 acute pediatric care, and a shared electronic health record.

For those children with SPMI in more traditional psychiatric practices—children who often go without primary care—I envision that primary care pediatricians and psychiatrists will make concerted efforts to engage the child and family in the pediatric medical home and to develop a co-management process. Through mutual agreement, documented in a family-centered and jointly-developed plan of care, the psychiatrist and pediatrician will determine their respective roles in sharing information, prescribing medication, monitoring its effects, assuring or providing psychosocial therapy, providing immunizations and other preventive services, coordinating with schools and childcare providers for their assistance in monitoring the child’s functional progress and their involvement in carrying out behavioral management, and managing transitions (eg, hospital or residential facility to home, adolescence to adulthood).

For the larger population of children with mild to moderate impairment and less acuity, I think child psychiatrists will increasingly become physician-to-physician consultants to the primary care physicians who directly provide their care. I envision pediatricians working with child psychiatrists to develop protocols that guide the management of these children (much as pediatricians are already doing with medical subspecialists to guide the care of children with common medical conditions such as gastro-esophageal reflux and migraine headaches, which have too often inappropriately consumed subspecialty resources). I think new technologies and new applications of existing technologies (telephone, video, etc.) will enable psychiatrists to provide consultative support remotely. I envision a growing number of child psychiatry consultation programs, offering education to primary care physicians in a given region, assistance with assessment and triage of individual patients, guidance toward appropriate community resources, and decision support related to prescription of psychotropic medications and primary care management (See the National Network of Child Psychiatry Access Programs at <http://web.jhu.edu/pedmentalhealth/nncpap.html>). Financial support of both the primary care clinician and psychiatrist in such models will require new funding streams or braiding of traditional funding streams in new ways.



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Interview with Professor Jane Foy (cont'd 2)

As payment for value replaces payment for service and as health systems integrate vertically, I anticipate that pediatricians and child psychiatrists will partner in ways that create joint accountability for use of behavioral health services and achievement of outcomes. This will, hopefully, break down some of the barriers that currently have us practicing in separate silos. It will also force development of practice- and community-level systems that educate and support the child and family in self-management, monitor adherence to treatment, and intervene to minimize unnecessary utilization of costly service sites such as hospitals and emergency departments. I hope that multi-disciplinary practice will become more common. A psychologist or social worker integrated into the primary care setting will be able to assist with behavioral health assessment, interface with the child's school, provide psychosocial therapy, collaborate in framing clinical questions for the psychiatrist, and serve as liaison between psychiatrist and primary care clinician—adding to the efficiency of the psychiatric consultation process and enriching the experience of the clinicians involved. Involvement of peer support specialists on primary care teams can bring additional benefits, such as assisting families in navigating the behavioral health system and supporting children in developing the life skills necessary to achieve their personal goals.

3. What do you think the biggest barriers have been to achieving such a collaboration in the present?

Pediatricians often cite poor communication as the major barrier to collaboration with behavioral health professionals. An important factor is the culture of privacy in behavioral health—an essentially good thing sometimes taken to the extreme. When pediatricians refer to medical and surgical subspecialists, we are accustomed to sending or telephoning our history and clinical questions to the specialist and receiving information back (spontaneously!) regarding the initial assessment and each office or hospital visit thereafter, typically with guidance about interim care of the child. Such communication is supported by electronic record systems that typically prompt the specialist to communicate with the primary care physician and may even track completion of this communication. By contrast, pediatricians referring a child for behavioral health services often do not have the opportunity to share their history and clinical questions because the child typically enters an intake process that is blind to the referral source; and although HIPAA actually allows a primary care clinician and behavioral health clinician to share information about a mutual patient, even without the patient's consent except for records of psychotherapy and substance abuse treatment, privacy concerns and the absence of office systems to support this communication often keep behavioral health providers from sharing information with the pediatrician. The pediatrician may not even know that the child is receiving behavioral health care, much less what type of behavioral health care the child is receiving. Families—often stigmatized by the child's behavioral health condition and unaware of its implications for the child's medical care (eg, interaction of medications; impact of anxiety, depression, or inattention on adherence to medical treatment)—may not spontaneously inform their pediatrician. Lacking information from behavioral health professionals, pediatricians cannot partner in the child's mental health care, coordinate care of co-morbid medical conditions, build a relationship with the behavioral health professional, or learn from the experience.

Pediatricians must, however, share responsibility for ineffective communication with psychiatrists. We are often unaware of the rhythm of psychiatric practice, the difficulties posed by interruptions, and the minimal administrative support available to most psychiatrists.



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Interview with Professor Jane Foy (cont'd 3)

We would do well to develop personal relationships with our psychiatric colleagues and an understanding of the preferred timing and mode of communication with them. Agreement on a faxable form for the bi-directional sharing of critical information and mutually-convenient times for telephone conversations are examples of concrete steps that pediatricians and psychiatrists can take to enhance communication.

Payment—or rather, lack of payment—has also been a daunting barrier to collaboration. Fee-for-service arrangements rarely pay either the pediatrician or the psychiatrist for aspects of care that are not face-to-face with the patient. This leaves pediatrician-psychiatrist communication as an uncompensated activity. Furthermore, most behavioral health payment systems require that a procedural code be accompanied by a diagnostic code specifying a behavioral disorder. However, many children in need of mental health services do not have a diagnosable disorder. Pediatricians commonly face children with a positive psychosocial screening test and an undifferentiated problem, children whose symptoms are just emerging, children with impairing symptoms that do not rise to the level of a disorder, and children whose parents have mental health problems that impair the parents' functioning as caregivers and/or whose stressful environment has toxic effects on the child. In all these situations, neither pediatricians nor psychiatrists have mechanisms that adequately pay them for care of the child and family or collaboration with each other.

4. How do these collaborative models translate internationally, particularly in low/middle income nations?

I do not have expertise in global health; however, I am aware that virtually all low income nations and many middle income nations have shortages of child psychiatrists even more severe than our own and a general paucity of specialty behavioral health resources. The AAP Task Force on Mental Health actually drew from the work of the World Health Organization (WHO) in developing guidance for the primary care assessment and management of commonly-presenting children's behavioral health problems. [Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit. American Academy of Pediatrics, Chicago, Illinois, June, 2010.] The WHO guidelines assume that in countries with insufficient behavioral health resources, primary care is often the entry point for children with behavioral health problems. They further assume that primary care clinicians can be equipped to screen children for psychosocial problems, identify children exposed to traumatic events and toxic environments posing health risks, triage for psychiatric emergencies, offer initial behavioral interventions, and identify those children and families who require behavioral health specialty consultation. Clearly, such a model requires training of the primary care clinician by a behavioral health specialist and access to a specialist for consultation in situations beyond the expertise of the primary care clinician, such as care of children with severely impairing symptoms. Psychiatry consultation models such as those I have described in the U.S. have theoretical application to other countries as well, particularly models allowing for remote location of the psychiatric consultant. Such models would benefit from the inclusion of mid-level behavioral health professionals positioned within the primary care setting to serve as liaison to and from the psychiatrist.

5. On a global level, what positive outcomes do you anticipate from optimized collaboration between primary care providers for children and child mental health specialists?

I assume by "optimized collaboration" we are speaking about collaboration in training pediatricians for an enhanced role as mental health providers, in training child psychiatrists for their new role as consultants to primary care clinicians, and in developing and implementing new collaborative practice models.



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DeInterview with Professor Jane Foy (cont'd 4)

As a result of optimized collaboration I believe we would see increased access to mental health services for children at all levels of the severity spectrum: I believe it would increase the likelihood that children who have experienced adverse childhood events and exposure to toxic stress will be identified and offered preventive care. It would increase the likelihood that behavioral health problems will be identified and treated earlier in their course. Earlier intervention would be more effective and ultimately reduce the demand for specialty resources among children with conditions of mild to moderate severity. When specialty resources are needed for those children with conditions of high severity, those resources would become more accessible.

Benefits would accrue beyond health. These enhancements in health care would increase the likelihood that children will accomplish developmental milestones, complete their education, and transition successfully to adulthood. Given the fact that the majority of adults with mental illness experience onset of their symptoms during adolescence, these enhancements also hold the promise of improving quality of life across the lifespan.

6. Is there any other practical advice you can give to us child and adolescent psychiatrists in practice, in education?

I think it is important for child and adolescent psychiatrists to recognize that pediatricians have a role in mental health care that is different from that of psychiatrists. A child and family presenting to a child psychiatrist for care have recognized a need for mental health services or experienced a mental health crisis that precipitated the visit. A child and family may present to a pediatrician in similar circumstances, or they may present in any number of other ways: they may have a concern they do not think is mental health in nature, such as a somatic symptom, irritability, growth failure, or poor school performance; the child may be asymptomatic but have behavioral health risk factors such as poverty, parental mental illness, or exposure to violence; the child may have a positive psychosocial screening test during a routine check-up; the child may have a chronic medical condition that is poorly controlled because of unrecognized, comorbid anxiety or depression; the child may have symptoms that are impairing without rising to the level of a diagnosable disorder. The role of the primary care pediatrician is to respond to each of these circumstances. "Generic" or "common factors" communication skills—techniques drawn from evidence-based therapies and shown to be effective across a range of mental health problems—are foundational and readily acquired by experienced primary care physicians. [Pediatrics. 2008; 121(2):266-275] Child and adolescent psychiatrists should become effective trainers in these skills.

The pediatrician has many other assets that can be applied to mental health practice: for example, longitudinal relationships with the child and family; knowledge of child development and parenting; expertise in collaborative management of chronic medical conditions (readily applied to children with behavioral health problems); relationships with schools and other youth-serving agencies; office systems to support chronic illness care; and team leadership within the medical home. At the same time, many pediatricians lack formal training in mental health assessment and treatment; for this reason, they rely on child psychiatrists to educate them in these areas and to share the care of patients with complex mental health needs and psychiatric emergencies. Successful collaboration between pediatricians and child and adolescent psychiatrists begins with recognition of our complementary roles, strengths, and needs.

(Professor Foy was interviewed by Professor Guerrero)



The Jubilee International Conference "Models in Psychiatry"

Dr. Mohamad Khalid, Secretary General of the conference (KSA)

Prof. Norbert Skokauskas, Secretary General, WPA CAP (Norway)

Saudi German Hospital and the Saudi Psychiatric Association (SPA), in collaboration with Psychiatric Hospital Jeddah, Motmaenna Psychiatric Centre, Institute of Psychiatry Ain Shams University, the Egyptian Psychiatric Association, Kasr Al-Ainy Psychiatry Department, Cairo University, and the WPA organized the 10th International Conference in Jeddah, Kingdom of Saudi Arabia (KSA), 17 – 19 April 2014. The Jeddah congress is one of the largest and most important psychiatric meetings not only in the Kingdom, but also in the entire Middle East region. Every year the Jeddah conference has a designated theme, and the theme of the 2014 conference was models in psychiatry. The conference continues to grow, and this year it featured speakers from Australia, Asia, Africa, North America, the Middle East, Europe, and Russia. There were a number of distinguished speakers. In this paper we would like to acknowledge two international speakers whose presentations attract large audiences year after year and who have been repeatedly invited to present in Jeddah.

Professor Ahmed Okasha (Egypt) was the guest speaker and also honorary chairman of the conference. Prof. Okasha is a well known figure in the world of psychiatry. He is Past President of the WPA (2002 – 2005), Director of the WHO Collaborating Center for Research and Training in Mental Health based at the Institute of Psychiatry (named after him) of Ain Shams University, President of the Egyptian Psychiatric Association, and Honorary President of the Arab Federation of Psychiatrists. Professor Ahmed Okasha gave a keynote address on antipsychotic use in adults. Prof. Hans-Jürgen Möller, Past Chairman of the Department of Psychiatry at Ludwig-Maximilians-University, Germany gave another keynote address at the meeting. Several parallel workshops and training courses were organized, including a three day training course in CAP. The congress in Jeddah was a great success, where fruitful scientific, spiritual, and cultural experiences were shared. We want to thank all speakers, attendees, and organizing committee members, especially Dr. Mahdi Abou Madini, Congress Director, Associate Professor and Consultant Psychiatrist and Chairman of the Department of Psychiatry at Dammam University, President of the SPA, and Acting Pre Arab B of Psychiatry; and Dr. Mohamed Shawoosh, Congress Chairman and Consultant in Psychiatry at Psychiatric Hospital Jeddah.



Prof. Ahmed Okasha,
Past President of the WPA in
Jeddah, KSA



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Dr. Khalid Bazaid leads the second Child and Adolescent Psychiatry training course in Jeddah, KSA

"World CAP" Editors

The first Child and Adolescent Psychiatry training course in the Kingdom of Saudi Arabia was organized a year ago. The second training course was organized in Jeddah, 18 - 20 April 2014.

Child and Adolescent Psychiatry still remains a growing sub discipline in many countries of the Middle East. CAP postgraduate training is not well established, as it is in North America or Europe. Hence, junior doctors from the Middle East quite often leave for North America to enter post graduate training in psychiatry. Still, however, there is an urgent need to have a short and intense CAP training course in the KSA and the Middle East until a world class CAP fellowship program can be established locally.

Dr. Khalid Bazaid and his team, for the second year in a row, organized a CAP training course in Jeddah. The faculty mainly consisted of overseas-trained Saudi child and adolescent psychiatrists; however, a number of international speakers were also present.

The audience was diverse and included child and adolescent psychiatrists, adult psychiatrists, pediatricians, psychologists and allied professionals. This diversity among the participants was important, as in the Middle East there is a lack of child and adolescent psychiatrists, and children with mental health needs quite often are seen by adult psychiatrists and pediatricians.

The course was tailored around the cultural values of Saudi attendees. At the same time, the 2nd CAP course was interactive, dynamic and stimulating. It provided a good balance of up-to-date evidenced-based lectures, clinical case discussions, and transcultural child and adolescent psychiatry forums.

No doubt, such courses improve local services by improving mental health providers' competence and ability to ultimately contribute to better health in children.





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