



# ***World Child & Adolescent*** **Psychiatry**

ISSUE 17, December 2019

Improving child and adolescent mental health by connecting global wisdom with everyday practice and advocacy

World Psychiatric Association,  
Child and Adolescent Psychiatry Section's  
Official Journal



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## Chair's Column:

Dear Colleagues,

Welcome to the final 2019 issue of "World Child and Adolescent Psychiatry," an official newsletter and journal of the World Psychiatric Association, Child and Adolescent Psychiatry (WPA-CAP) Section. 2019 was yet another busy year, and I wish to thank all colleagues who contributed to the section's activities. This one-page editorial is too short to list all these activities; however, I wish to draw your attention to a few activities that perhaps received less attention than they deserved.

The WPA-CAP section initiated and led three regional consortiums that focused on academic child and adolescent psychiatry. In 2019, the Consortium on Academic Child and Adolescent Psychiatry in the Far East published a five-year followed up study, while the Consortium on Academic Child and Adolescent Psychiatry in the Middle East and the Consortium on Academic Child and Adolescent Psychiatry in Southeast Europe published their initial findings. Many colleagues collaborated on these projects, and special thanks go to Prof. Anthony Guerrero (USA), Dr. Tomoya Hirota (USA/Japan), Dr. Hojka Gregorič Kumperščak (Slovenia), Ms. Carolyn Clausen (Norway/USA), Dr. Khalid Bazaid (Canada/Kingdom of Saudi Arabia), Prof. Muhammad *Waqar* Azeem (Qatar), Dr. Masaru Tateno (Japan) and Prof. Norman Sartorius (Switzerland).

In 2019, with leadership from the WPA-CAP Section, leaders from the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP), the World Association for Infant Mental Health (WAIMH), and the International Society for Adolescent Psychiatry and Psychology (ISAPP); the United Nations (UN) Special Rapporteur on the Right to Health; representatives from the World Health Organization (WHO) Department of Mental Health and Substance Abuse; and other experts jointly published the paper, "Shaping the future of child and adolescent psychiatry," which outlined four consensus priorities for child and adolescent psychiatry over the next decade.

In this current issue of "World Child and adolescent Psychiatry," you will find, among other publications, several papers that hail from North America, Europe, the Middle East, and Asia and that examine different aspects of digital child and adolescent psychiatry. It is a diverse group of papers, but all of them share the hope that digital child and adolescent psychiatry can improve care for our patients. In fact, the WPA Child and Adolescent Psychiatry section has proposed, and WPA President-Elect Dr. Afzal Javed has accepted, a suggestion to have digital psychiatry as a part of the 2020-2023 WPA Presidential initiative. Colleagues who are interested in digital child and adolescent psychiatry will therefore have the opportunity to join with WPA forces to improve treatment outcomes for children and adolescents. Many more things will come in 2020. Happy Festive Season and Prosperous 2020!

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





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## **What is the Big Deal about Big Data?**

Professor Bennett Leventhal (USA)



Child and Adolescent Psychiatry has long prided itself on being a scientific discipline although the nature of our science and our discipline has varied over time. The reasons for this are manifold. Interest in child development and developmental psychopathology focused initially on single case reports. This tradition included both Sigmund Freud and Anna Freud and helped identify many important clinical syndromes. Small samples followed the single case reports but were equally monumental. Sir William Gull created the label “anorexia nervosa” in an 1873 paper describing 3 young women. Bradley’s initial report (1937) on the use of Benzedrine to treat ADHD included a relatively large sample of 30 youth and Kanner’s 1943 paper defining the syndrome of autism included only 11 individuals. Despite these small sample sizes, the field moved forward. Thus, for much of the early history and progress in child and adolescent psychiatry, as well as the rest of medicine, has depended on small samples; the discoveries and advancements have been remarkable!

With the advent of modern psychopharmacology and other treatment studies, there was an interest in larger data sets. There are many reasons for this are many. Among them are attempts for statistically significant findings when effect sizes are modest and another is to allow for corrections due to multiple comparisons. Samples sizes have also grown with large-scale national registry studies and epidemiologic studies looking at relatively uncommon disorders in total population. In these latter examples, the sample sizes have grown to 50,000, 100,000 and millions of participants. Finally, genetic studies have found the need to have very large populations to detect rare genetic variants that make significant contributions to disease. Genetic association studies of 20 to 30 years ago, with sample sizes of less than 100 or a few hundred saw effect sizes dwindle with replication to the point that virtually no findings consistently replicated. More recent genetic studies of disorders like hypertension, diabetes, schizophrenia and even autism are now look at sample size of 10’s of thousands if not hundreds of thousands of individual. With these numbers, have we actually arrived in the era of “big data?”





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Being able to collect and store large amounts of data is a relatively new phenomenon. Only recently have digital storage devices had the capacity (size) and speed (read and write rates) to store very large amounts of data. For those who started early in the computer world, we were impressed with kilobytes and megabytes. We now think about data in terms of Gigabyte (GB;  $2^{30}$  bytes); Terabyte (TB;  $2^{40}$  bytes), Petabyte (PB;  $2^{50}$  bytes), Exabyte (EB;  $2^{60}$  bytes), Zetabyte (ZB;  $2^{70}$  bytes), Yottabytes (YB;  $2^{80}$  bytes) and the proposed Hellabyte (HB;  $2^{90}$  bytes) and Brontobyte (BB;  $2^{100}$  bytes). So, at what point are we dealing with “big data?”

Just for reference: one terabyte is enough space to store about 1 billion pages of text and one yottabyte can store  $10^{21}$  pages of text. Similarly, it takes approximately 1 gigabyte to store one copy of a human genome. A 24-hour EEG monitoring is 5-10 GB. How many genomes or MRI images does one need to collect in order to be in the realm of “big data?” Well, we are not asking the right question. As it turns out, “big” does not just refer to size, although size is important.

At this point, it should be obvious that the notion of “big data” is a bit confusing, at least in the media and amongst many of us who are not involved in this area of work. Surely, “big data” implies lots and lots of data but it more than that. “Big data” really refers to a field of science that uses datasets that are too large or too complex for exploration with traditional data processing and statistical methods, as well as small multiprocessor computers. Not only does “big data” refer to a large quantity of data but also the science of gathering, analyzing and extracting information from these large complex datasets.

There are generally four critical elements of big data:

1. Volume – the amount of data to be collected and stored
2. Variety – the types and nature of data to be stored and analyzed, e.g., audio, video, numbers, text, etc.
3. Velocity – the speed at which the data must be generated and processed to meet the needs of the particular process
4. Veracity – this applies the quality or accuracy of the data; for big, complex dataset, it is almost impossible for humans to check the accuracy of all elements meaning that there is usually a certain element of error.



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Large, complex datasets are found in all areas of work, including meteorology, astronomy, physics, engineering, genomics, connectomics, and healthcare.

Healthcare and related research is why we are interested in “big data.” The large, complex dataset that we use in this regard is the electronic health record (EHR). There can be no argument about the size of the dataset including all the EHR's in a single hospital but, imagine the size of dataset that includes all the health records for a healthcare system, or entire country! However, not only will this dataset be large, it will also have widely disparate types of data, ranging from numeric data like height, weight, blood pressure and heart rate to imaging data. Then, there is the narrative or “free text” data. The incorporation of these varying types of data is a challenge, even before any analytic work can be done. There are multiple ways to do this but one commonly used framework in healthcare is the i2b2 database (Informatics Integrating Biology and the Bedside. This sophisticated databasing tool allows for the collection and organizing of many varying types of data and preparing it for analysis.

The ultimate goal of “big data” in healthcare is to use advanced analytic techniques that predict outcomes, identify risk, identify opportunities to prevent or treat disease, characterize healthcare system flaws, identify new correlational events, and much more. By use such large datasets, events with relatively small effective sizes can be identified and the examined in more detail.

Now that we understand all of this, what is the big deal about “big data?” As is often the case, there is good news and bad news.

The bad news is that for child and adolescent psychiatry, the mental health records are often separated from general medical records; this means that mental health data are often not incorporated into large EHR datasets. Additionally, we often have a limited amount of data and much of that is free text. EEG's, neuroimaging, EKG's, and other relevant lab tests and measures are uncommon. We generally do not even have vital signs at every visit. This means that our “big data” lacks complexity – our patients are complex but our data may not be so complex. Moreover, even with size, the lack of complexity limits the utility of the data. Finally, there is the general concern about maintaining privacy when sharing EHR's. This is a concern across all “big data” work: it is not clear how well anonymizing procedures can effectively protect privacy, especially given the sophisticated analytic tools that have been developed.



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The good news is that, in many places, the child and adolescent psychiatry record is a part of the general medical record so that our findings and care patterns are part of the analytic strategies used to examine all aspects of healthcare. This means that data found in the EHR can be correlated with child and adolescent psychiatry data to identify new patterns that will be relevant to the diagnosis and treatment of our patients. The addition of new information, such as practice guidelines, into the big dataset will create opportunities to develop electronic decision support tools that will allow us engage in evidence-based practice more efficiently and effectively.

So, what is the big deal about “big data?” “Big data” is a developing tool that, over time, will have a large impact on the science and practice of Child and Adolescent Psychiatry. However, “big data” is a developing tool and science. Its full utility is yet to be realized and is surely unknown. Nevertheless, with the addition of artificial intelligence and machine learning, the potential is enormous. We need to be following this closely and, when possible, participate in “big data” development and studies so that our interests in developing and developmental psychopathology are well represented.

In the meantime, we also need to pay attention to “small-data.” Reporting on small scale studies of 10’s and hundreds of patients who are carefully ascertained and phenotyped as well as placed in treatment or naturalistic follow-up studies will still be important. Careful attention to research methods with relative small(er) samples, including data analysis, will be central to clinical and basic science for years to come.

Is “bigger better?” Only time will tell. In the meantime, it is important to keep an open mind – just not so open that your brains fall out.



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## **Neuroanalysis: Computational Neuroscience in Psychiatry**

Dr. Abraham Peled (Israel)

Computational Neuroscience is a rapidly maturing field of science boosted by the byproduct of Artificial Intelligence accompanying it.

From Computational Neuroscience we learn about the optimization that the brain archives to generate higher mental functions. These are emergent properties of global brain organizations and when optimal global brain organization is perturbed, breakdown patterns of brain organizations emerge as the phenomenology of the different mental disorders.

Emergent properties are typically defined by the statement that the “whole is more than the sum of its parts”. This is true for systems characterized by non-linear interacting elements. The emergent properties evolving from the complexity of the brain are phenomena such as consciousness, mood, and personality. One neuron, or even a large group of neurons, do not show characteristics such as consciousness, mood and personality. However, the whole brain integrative activity does. Thus, in disturbances to consciousness, mood and personality, we assume that whole brain organization will be influenced.

As for brain network dynamics, the hypothesis is that mental disorders are disturbances to the optimal whole brain organizations with hubs set as Central Executive Networks for fast millisecond range plasticity, Default-Mode Network for lifelong stable plasticity and Salient Network for in-between months, weeks, plasticity adaptations. Different phenomenological manifestations of mental disorders are caused by different types of neuronal network “breakdown” patterns. These can be conceptualized in terms of disturbances to plasticity network dynamics.

Plasticity is the term reserved for interactions taking place between, and among, neuronal network systems in the brain (neurogenesis and synaptic activity), these are typically interactive with external environments via sensation (sensory systems) and actions (motor activity). The disturbances to brain plasticity-dynamics can be defined by their time-scales and interactions with the environment. ‘Cognizance Plasticity’ is the fast millisecond-range plasticity interactions within brain networks, ‘Reactive Plasticity’ is slower minutes-range interactions within brain networks and serves their stabilization during interactive perturbations from environmental stimuli. ‘Adaptive Plasticity’ is an even slower process of synaptogenesis and neurogenesis occurring over weeks and months. Finally ‘Developmental Plasticity’ relates to the lifelong processes that shape brain organization by experiences, also sometimes called ‘Experience-dependent-plasticity,’ and refer to the internal representations and configurations, a model of the external world shaped by experience from birthhood to current occurrences.





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## *Cognizance Plasticity*

“Cognizance Plasticity” is in the millisecond range integrating brain organizations, that of Central Executive Network, from instant to instant with the emergent property of Consciousness and the capabilities of cognitive functions such as problem-solving and action planning. The brain is organized as a network with connectivity and hierarchy, thus altered Cognizance Plasticity involves disconnection or over-connection and hierarchical bottom-up or top-down connectivity alterations.

## *Reactive Plasticity*

Reactive Plasticity is somewhat on a longer timescale. Cognizance Plasticity, that of minutes to hours, stabilizes the Cognizance plasticity in the face of perturbations caused by large alterations of environmental dynamics (i.e., stress). Large alterations of environmental dynamics, that typically characterize stressful occurrences perturb and destabilize the fast (millisecond-range) plasticity and thus requires a more lasting connectivity stabilization of Reactive Plasticity to “hold it together.”

## *Adaptive Plasticity*

Adaptive Plasticity” is slower. It spans time-scales of weeks. It reflects Hebbian Dynamics creating memories where neurons that fire together increase the connections between them (wire-together). Adaptive Plasticity sustains memories, which in turn build internal representations of the environmental occurrences. In effect, the fast Cognizance Plasticity, slower Reactive Plasticity, and even slower Adaptive Plasticity generate an internal model of the environmental events in the brain. Such an internal model of the world organizes brain dynamics to predict and optimize the interactions with the environment ensuring optimal effective survival for the individual. The brain acts to minimize the differences (Delta) between psychophysical occurrences in the environment and the internal brain-model of these same environmental occurrences.

This is done by continuous “update” of the internal model based on sensory activity and by continuous adaptive interventions in the environment via motor activity in the surrounding environment. Thus, the slower Adaptive Plasticity is the one responsible for minimizing brain-environment bias (reducing free energy or delta in mathematical physical terms). This is done with Bayesian dynamics where the brain continually makes error predictions and corrections interacting with the environment. The Salient Network subcortical hubs are probably most operational for such intermediate-range (weeks months) plasticity regulation activity.



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## *Developmental Plasticity*

Finally, Developmental Plasticity results from life-long processes of all the above plasticity dynamics. This lifelong developmental process is often defined as “Experience- Dependent Plasticity” and is composed of long-lasting memories embedded in the brain network-configurations because of life-long Hebbian dynamics. The total life experiences acting on the developing brain from its first developmental stages create a lasting stable basic neural-network organization in the brain that encodes internal representations of the environment including occurrences that are more complex; those of social interactions including self and others-representations. Such neuronal network organization in the brain is basic (at rest), and is conceptualized as the “Default-Mode-Network” because it is apparent when the brain is not engaged in stimulated rapid cognitive-related action. The emergent property from the activity of basic developmental Default-Mode-Network is the Personality style, reflected in the reactions and attitudes “shaped” by the life-long experiences of the individual.

According to the above conceptualizations, psychiatric disorders can now be reformulated. Disturbances to the fast millisecond-range Cognizance Plasticity will disturb conscious integration with symptoms of psychosis and schizophrenia. Disturbances to Reactive Plasticity, the reactive stabilization of neural networks in the face of environmental perturbations, result in the emergent phenomenology of anxious sensations and anxiety symptoms. The disturbances to slower Adaptive Plasticity that optimizes internal representations and reduces predictive error will result in mood disorders. De-optimized brain with free energy increases results in the emergent property of depression and vice versa. Optimization dynamics are mood-elevating i.e., possible manic symptoms. Finally, altered internal representations of psychosocial occurrences due to “immature” biased Default-Mode resting brain network organization result in personality-related distortions, which lead to ineffective, biased social interactions and an emergent property of personality disorders.

Table 1 summarizes the plasticity disturbances and their phenomenological correlates

Plasticity disturbance	Network involved	Brain system disturbance	Psychiatric phenomenology
Cognizance Plasticity	Central Executive Network	Disturbance to millisecond range integrating brain organizations. Disconnection or over-connection and hierarchical bottom-up or top-down connectivity are disturbed	Psychosis and schizophrenia (negative signs)



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Reactive Plasticity	Salient Network	Disturbances to longer timescale those of minutes to hours, the stabilizing network plasticity in the face of perturbations caused by large alterations of environmental dynamics (i.e., stress).	Anxiety (general, reactive, phobia)
Adaptive Plasticity	Salient Network	Disturbance to slower time-scales, those that span hours to weeks and are responsible for reducing free energy. The differences between internal representations (memory constructs) and external environmental occurrences. De-optimization takes place when free energy increase and mismatch between internal representations and external events become larger	Mood disorders
Developmental Plasticity	Default mode network	Disturbances to the Default-Mode Retesting brain network organization resulting in distortions of internal representations of the psychosocial world which lead to ineffective biased social interactions	Personality disorders

## *Digital Psychiatry*

With the development of the connecting internet and sensor technology (e.g., face speech recognition) mental status examination can be easily extracted and delivered over distance (telepsychiatry).

It is well-known that the smartphone we all have can act as a set of sensors that can provide continual monitoring of our activity and thus also to our disturbances in activities. The oscillometer in the smartphone can detect restlessness or slowness, the GPS can monitor outdoor activity or tendency to confinement, the microphone can pick up speech alterations such as the



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volume of speech and patterns of vocalization, thus slow reduce speech in depression, for example, can be detected. Finally, the camera can pick up facial expression then analysed with existing Artificial Intelligence (AI) face recognition software and apps (e.g., Affdexme)

With the help of AI the extracted psychiatric phenomenology can be interpreted to match most of the diagnostic process of a skilled psychiatrist. Once achieved continual psychiatric monitoring coupled with the new technology of wireless dry-electrode electrophysiological brain imaging can begin and collect big-data. Big-data analysis stands a good chance to reveal the etiological correlations between mental disorders and their brain-related origins. Thus, etiology for mental disorders can begin to unravel.



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## **Clinical decision support systems for child and adolescent mental health services**

Carolyn Clausen (Norway)

### **I. Challenges**

Close to one-half of all mental health disorders develop prior to the age of 14. While many of these illnesses are single episodes that resolve, they can become chronic, or even lifelong conditions. Globally, one-quarter of disability-adjusted life years (DALYs) for mental and substance use disorders occur in youth. Early evaluations, diagnosis, and treatment are critical to shortening single episodes of care, reducing possible comorbidity and long-term disability. As children and adolescents are particularly vulnerable, they, along with their families, require specialized early intervention and preventive services. However, there is a high demand for care placed on a limited number of specialists and wait-lists to receive their care continue to grow.

To meet the demand for care expansion of the current workforce is essential, including support for specialized child mental health services and allied professionals. Without proper treatment, disorders arising in childhood and adolescence can lead to dramatic social and medical disabilities that greatly impact the individual, family, and community. Proper professional training, additional posts, and new services can help avoid long delays in receiving specialized child and adolescent mental health care. International organizations, including the WHO, have called for innovative, collaborative and sustainable approaches to capacity building of these specialized child and adolescent mental health services. Implementing digital health interventions (DHIs) can help to find innovative and sustainable ways to support and expand services. While DHIs are integrated within other areas of medicine, child and adolescent mental health has not yet fully benefited from these technological advances. The addition of DHIs within the child and adolescent mental health care system is crucial to address the needs of youth affected by mental disorders.

### **II. Digital Child and Adolescent Mental Health**

While still in development, digital child and adolescent mental health is an innovative and potentially sustainable approach to care. DHIs can enhance care services, improve cost efficiency, and expand the understanding of mental illness in childhood and adolescence. Current DHIs range from, remote therapeutic services held on-line, to clinical decision support systems (CDSS). CDSS are advanced DHIs, designed to enhance care by providing clinicians with step-by-step guidance for evaluation, diagnosis, and treatment. The support provided is based on evidence-based, standardized guidelines, big-data sets, and data from aggregated EHR systems. While the vulnerability of the patient population and stigmatization continue to pose challenges to digital child and adolescent mental health progression, today's DHIs provide new and secure opportunities to address these challenges.





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## III. IDDEAS

The Individualised Digital DEcision Assist System (IDDEAS) is a new CDSS for child and adolescent mental health services. This CDSS focuses on preventive care, early diagnosis and early intervention, as well as treatment and case management for ADHD, with plans for expansion to address additional disorders. The Individualised Digital DEcision Assist System (IDDEAS) uses the latest clinical guidelines and health datasets along with data aggregated from EHRs to present clinicians with evidence-based support in real-time.



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## A Roadmap to Understanding Systems of Care in Child and Adolescent Psychiatry

Dr. Veeraraghavan J. Iyer (USA), Dr. Stephanie Kuntz (USA), Dr. Salma Malik (USA)

### Introduction

Psychiatry has evolved from the confines of the proverbial 'couch' to a prolific system of healthcare. Psychiatry is no longer a branch of medicine that operates in isolation out of 'Retreats' and 'Insane Asylums'. In fact, as more and more evidence piles up, it becomes clearer that psychiatric systems are some of the most utilized systems worldwide. It is, therefore, not surprising to hear that depression is extrapolated to rank as the second leading disease burden among adults by the year 2020. It is also well established that the onset of most psychiatric symptoms occurs in childhood and adolescence. This makes the understanding of systems of care in child and adolescent psychiatry all the more important.

Basic economic theory dictates that increasing psychiatric demand will generate a need for services. Psychiatric services have, hence, come to represent a dizzying array of services. With burgeoning competition, research-based evidence is becoming the deciding factor for reimbursement and adoption of services by institutions. More robust the evidence for a therapy modality, more the confidence to implement it and fund it.

In this report, an attempt has been made to explain various globally applicable concepts of the child and adolescent psychiatry system, particularly those related to access, utilization, cost vs. outcome, and the realities that govern reimbursements.

### Access

Access to care, as defined by the Institute Of Medicine Committee on Monitoring Access to Personal Health Care Services (1993) is-

*The timely use of personal health services to achieve best possible health outcomes.*

With growing evidence supporting the efficacy of community-based services, there has been a shift in child psychiatry landscape from congregate care settings such as group homes and long-term care hospitals to community-based care systems such as in-home therapy services and outpatient services.

Since the demonstration of Mental Health Services Program for Youth (MHSPY) project in Massachusetts in 2006, wraparound services have become an integral part of most community-based systems. This project demonstrated the efficacy of a home-based care management program that coordinated various disciplines of care in youth with severe functional impairment. It showed an inverse relationship between care coordination and emergency service utilization and overall cost with improvement in perceived family satisfaction.



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## **Utilization of services**

For the sake of simplicity, the utilization of services could be categorized into:

a) Utilization of emergency services and b) Health insurance utilization

### a. Utilization of emergency services

Emergency services are intensive services requiring detailed and swift analysis of the presenting problems to devise a systemic differential diagnosis and treatment planning. Generally, emergency services require significant time and cost investment. Thus, increased emergency service utilizations are a crude measure of healthcare profits lost.

### b. Health insurance utilization

The benchmark used by insurance providers is 'per member per month' (commonly abbreviated as PMPM). This is the number of units of services (calculated in money used) utilized per member per month. Insurance-based researchers use this to estimate and compare the cost of services such as emergency visits, inpatient stays etc.

## **Cost**

There is evidence that preventive, screening, early diagnosis and treatment services help reduce the long-term cost of supporting a decompensated medical/psychiatric condition. Thus, the use of such services gives an opportunity to help foster an optimal therapeutic environment is created in a cost-effective manner.

## **Outcomes:**

Outcomes could be classified as a) healthcare-related and b) social.

### a. Healthcare-related

Although data correlating improved care delivery and reduction of disease burden is lacking, it does support the efficiency of early screening and treatment models.

### b. Social

The burden of mental health on families is tremendous, financially and emotionally. The out-of-pocket expenses and the increasing families that cease to work as a result of their child's mental health demands suggests a significant financial burden on families. However, there are no research studies examining the effects of caregiver burnout and mental well-being.



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## **Summary/Discussion:**

Health management trends are guided largely from profit-driven principles and research-based evidence of treatment modalities, which often have little consideration for ground realities.

Care management services improve access to care. The disparities in access to healthcare systems are well established in lower socioeconomic groups and families with lower level of education. Lack of awareness is a major obstacle in access to care. Thus, creating awareness about access to mental health care seems an important mission. Families burdened by caregiving responsibilities face financial distress. Caregiver burnout is seldom discussed and not clearly studied.

Preventive primary care visits and school-based screening systems are the best strategies for early screening, referral and thereby efficient means of access to mental health. This strategy is promising considering the increasing incidence of children with mental health needs, the chronicity of their disabilities, and the cost of burden which is likely predicted to have an incremental trend.

Future directions for research to consider are sustained effects of wraparound and collaborative services, the correlation between emergency service use and increase in community services, emphasis on primary prevention models, interactions between child and adult mental health systems and strategies to improve access to services.



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## **Gaming Disorder: A Myth to Reality**

Drs. Aniruddh Behere and Jennifer Ondreyka (USA)

Gaming addiction has been a long-standing topic of debate among health professions. Yet, it was not until May 2019 that the World Health Organization (WHO) took a stance and gaming disorder was added to the International Classification of Diseases (ICD-11). While it is safe to say, that a large percentage of youth have participated in some form of online gaming, WHO has set specific guidelines for the diagnosis of gaming disorder. According to current diagnostic criteria, gaming disorder is defined as having increased priority given to gaming over other facets of life, impaired control over gaming, and continuation of gaming despite negative consequences. This behavior should persist for twelve months or longer in order to receive a diagnosis of gaming disorder and should have negatively impacted some form of social functioning whether it be familial, educational, occupational, etc.

According to various polls, around 75-80% of adolescents have self-reported playing online games within the past year. The majority of these adolescents are male, however, over 50% of the females surveyed, also reported participating in online gaming. Prior studies have estimated the percentage of video gamers who are addicted to being around 1.4% with males being nearly three times more likely than females to be classified as having an addiction to gaming. Other factors associated with gaming addiction include younger age, living alone, and poor psychosomatic health.

Before gaming disorder was added to the ICD-11, there was a long-standing controversy about whether or not a behavior such as gaming could even qualify as an addiction. The first behavioral addiction added to the ICD was gambling disorder, which set a precedent that behaviors and not only substances can in fact be addictive. Before this, the classification of an addiction disorder mainly applied to substances such as drugs and alcohol. Over the years, neuroimaging has revealed that behaviors, such as gambling and playing video games, have the potential to target the reward center of the brain in a similar way to drugs. Thus, it should not be surprising that these behaviors also have the potential to become addictive with persistent use by certain individuals despite harms caused in various aspects of life. That being said, DSM 5 currently does not recognize gaming disorder as an official diagnosis. In 2013 with the release of the DSM V, Internet Gaming Disorder was classified as a condition for further study.

In countries such as China and South Korea, compulsive gaming is seen as a serious public health issue for which there are established treatment facilities. In South Korea, there are public gaming centers referred to as "PC bangs," where gamers reportedly spend as many as 14-20 hours playing per day. Some individuals have even dropped out of school to play and are sacrificing sleep, proper hygiene, and socialization in exchange for more time devoted to playing video games. This resulted in the South Korean government enforcing a ban which prohibits minors from playing video games between the hours of midnight and six in the morning. This law has been largely unsuccessful as minors have found ways around the ban by borrowing the accounts of older individuals. Some worry that the United States may soon face a similar issue with the increasing popularity of video games among youth. Another aspect of video gaming is the advent of *Loot Boxes* and whether they are a form of gambling. Loot boxes are essentially items in video games that can be





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bought with real-work money. The current concern is related to whether there are similarities between loot boxes and gambling and if this can lead to issues related to gambling in video gamers, especially with minors.

On the other hand, many adolescents would argue that video games have been a positive factor in their lives; a source of entertainment, a coping mechanism for mental illness such as depression or anxiety, and/or a form of socialization, especially for those who may have difficulty socializing in person. In addition to research collected on the negative aspects of gaming, research has also shown that there are positive aspects of gaming as well. One study found that moderate videogame play has the potential to enhance life satisfaction and improve the player's well-being. Studies have also shown that playing action video games helps gamers with learning new sensorimotor skills, especially hand and eye coordination. Whether that actually translates beyond the virtual world into real-life situations remains debatable.

Additionally, the prevalence of gamers who would qualify for a gaming disorder is likely to be low (1-2%). Thus, there is the potential for false positives and diagnosis of individuals who may not actually qualify for a true addiction disorder. The risk of this is potentially stigmatizing a normal behavior and coping mechanism for many individuals. Most would agree that there is already a stigma associated with those who play video games and some worry that the classification of gaming disorder as an addiction may further stigmatize what could potentially be a positive behavior for many individuals.

The question remains how much time spent playing video games is too much? This is something that needs to be answered on an individual basis depending on whether the behavior is negatively impacting other aspects of the individual's life. Currently, most mental health providers are not formally taught to screen for excessive video game use and even if they do capture a patient who has an addiction to gaming, there has not been a formal consensus on how to approach treatment. However, the addition of gaming disorder to the ICD-11 opens the door for further research in the area of gaming addiction and potential courses of treatment. While current data has revealed that the majority of people who play video games will not become addicted, this new diagnosis may encourage providers to be more aware of the potential for addiction in certain individuals. Providers can encourage patients and their parent's in the case of children and adolescents to monitor how many hours are being spent playing video games and how this may be impacting other aspects of their life.



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## A Time of Crisis for Recruitment in CAP: Insider Tips from a Trainee

Dr. Asilay Şeker (Turkey) (CAP Secretary for the European Federation of Psychiatric Trainees, EFPT)

I decided to become a child psychiatrist when I was 4 years old. I was absolutely enchanted by the educational psychologist in my kindergarten. I was particularly impressed with how she met and listened to all the children there. So, I went to my mom one day and told her I wanted to be just “like that educational psychologist.” Then I was told that I could also become a psychiatrist, so I that can learn even more things about people and how they think. This opportunity was enough to convince me, so I decided on psychiatry.

My dear mom could not tell me to become a child and adolescent psychiatrist, because being a lawyer, she did not know that ‘such a “thing” existed some 23 years ago. I still ended up as one among very few who chose to be a child and adolescent psychiatrist, and we all know about the alarming global shortage of child and adolescent psychiatrists.

Through my role as the Child and Adolescent Psychiatry Secretary within the EFPT, I have the opportunity to network with many trainees from all over Europe. Based on our exchanges, I will try to give a reflection of what might work to attract more doctors to child and adolescent psychiatry.

**Increased Public Awareness:** Increasing public awareness of the existence and scope of CAP is important for many reasons and is particularly crucial to attract more people into the field. Just like the example of my own mother, the public has knowledge of child and adolescent psychiatry that is far from ideal. Moreover, it seems to be difficult to grasp the concept of mental health challenges in children. This difficulty, added to fervent antipsychiatry arguments, makes it even more important to raise public awareness of children’s mental health. This increased awareness will make it easier to advocate for the need for more child and adolescent psychiatric assessment, treatment, and prevention.

**Increased Pre-Medical School Exposure:** Many young people decide on their career path before they enter college. Adolescence is thus a critical period that should be targeted for enhanced exposure to different professions, including CAP. Exposure at school events and via other venues where youth can be reached (A.K.A. social media!) might prove crucial to recruit future child and adolescent psychiatrists.

As child and adolescent psychiatrists, we also have another unique channel through which we can be in contact with children and adolescents: our practice itself. The interaction we have with young people is a perfect opportunity to offer a glimpse of what CAP is about. This mechanism for exposure is probably not widely acknowledged, but a potentially effective one to create interest in the field.

**Increased Medical School Exposure:** Do all medical schools have CAP teachings within their Core Medical Curriculum (CMC)?

Is developmental psychiatric screening acknowledged as a universal core skill for doctors?



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It is not very difficult to keep adding questions to the ones above, and to realize that CAP needs more space in medical education. Medical school is where doctors master core competencies, and lack of exposure to certain branches of medicine almost automatically leads to reluctance to pursue a career in those branches. Therefore, the theory and practice of CAP should be hardwired in the CMC, including during the interning and foundation years. If we aim to increase recruitment into CAP, medical students should be made aware of all of the opportunities that a career in CAP offers, including in clinical work and in research.

Just like psychiatry, CAP can also easily be labelled as an outcast to “real” medicine, and its professionals as “barely doctors” in many countries. In that regard, the stigma that medical doctors have towards CAP should be acknowledged and challenged as well. The less counter-advertisement CAP receives from other specialties, the more welcoming it will seem for emerging doctors.

Although not adolescents anymore, medical students are also mostly young people. Information mixed with social events is more attractive than long presentations for many, so more interactive activities such as “Summer Schools” or “Meet the Expert” sessions can deliver more effective campaigning.

**Increased Exposure for Psychiatry Trainees:** In many countries, CAP still involves subspecialty training after a certain amount of training in general psychiatry. Recruitment efforts should therefore still go on through general adult psychiatric training. For various reasons, the rates of preferring CAP over other adult subbranches are far from ideal.

Because of lack of exposure to CAP during core general psychiatry training, many general adult psychiatry trainees consider themselves not competent enough to deal with children. This lack of exposure easily leads to drifting further away from CAP. Therefore, curriculum requirements should ensure that general psychiatry training is “general” not just because it offers training in a lot of different adult psychiatry subbranches, but because it also offers adequate exposure to CAP.

A similar problem exists for countries where there is no training available for CAP, even as a subbranch. In such countries, general psychiatrists can work with adults and/or children/adolescents. Not surprisingly, psychiatry trainees who experience such curricula very often delay any plans to decide on specialized CAP career differentiation. This delay leads to lack of CAP recruitment and should be addressed urgently.

The obvious global shortage of child and adolescent psychiatrists leads to more patients per provider and busier clinics. This high demand for services, added to the inevitably lengthier sessions required by young patients and their families (relative to individual adults), seems not so welcoming for trainees who can still opt for different psychiatry specialties with arguably less intense working conditions.

**Improved Working Conditions:** It is obvious that bettering the working conditions for child and adolescent psychiatrists will be a “pull” factor for medical students and trainees. Improving working conditions by devising a sustainable plan for maternity leaves (as the majority of child and adolescent psychiatrist in the workforce are female), creating enough space for non-clinical opportunities (including research, psychotherapy training/practice, and advocacy)



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and finding long-term solutions to counteract burnout related to workload are only a few of the very necessary steps to be taken. It is also equally obvious that all these improvements require a systemic change, with involvement from official bodies, in addition to individual-level efforts.

At this point, I would like to remind you again of how I decided to become a psychiatrist: this decision was not based on huge earning potential or on deliberate research on career advancement. This decision was based on pure curiosity in people and on inspiration from a lovely educational psychologist who presented in a “good enough” way to feed that curiosity. As supervisors, trainers, clinicians and professors you have this same inspirational power to attract people into the field.

On a final note, I would like to present EFPT as a passionate advocate for CAP training in Europe. EFPT leadership has put in a lot of effort to support CAP trainees. A short video where trainees and experts talk about “what’s great about CAP” will soon be available on various EFPT channels. Stay tuned and stay passionate about motivating coming generations!



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## **Developing a Trauma-informed Care & Response System in a Tertiary Mental Health Facility**

Ong Say How, Ann Marie Aboud, Loo Wee Shyon, Tracy Wee Ye Mei (Singapore)

### **Introduction**

Adverse childhood experiences (ACEs) have been identified as one of the most prominent and important contributing factors toward the development of childhood and adulthood psychopathology, including trauma-related problems and post-traumatic stress disorder (PTSD). The Institute of Mental Health (IMH), a tertiary mental health hospital in Singapore, has identified trauma-informed care and practices as a key area of need within the institution and decided to embark on a learning journey to understand about trauma-informed care and how it could be implemented hospital-wide, with the objectives of adopting evidence-based and trauma-informed practices to benefit patients, caregivers and hospital staff who could experience trauma symptoms during the delivery of care to their patients.

With support from the health ministry and the hospital, a study team comprising the four authors (OSH, AMA, LWS& TWYM) visited Philadelphia, New York and Providence, Rhode Island in the United States from 15<sup>th</sup> October to 2<sup>nd</sup> November 2018 with an objective to learn about Trauma- Informed Systems (TIS), The Sanctuary Model, and Trauma Systems Therapy (TST), and how these components contribute toward forming a larger trauma-informed care and response system.

A Trauma Systems approach further serves to engage IMH, using a common language and developing a common understanding of how to manage clients who have been traumatised, with other child-serving systems (e.g. schools, healthcare, child welfare, children's therapeutic group homes and the juvenile justice) as part of its multi-systems approach.

### **A) PHILADELPHIA**

The team-based study visit began in Philadelphia at The Children's Crisis Treatment Centre (CCTC), to study the Sanctuary Model under its author, Dr Sandra Bloom, a psychiatrist of Community Works, and CCTC Staff. CCTC is a private non-profit agency that specializes in providing behavioural health services to children and their families.

The team learned that the evidence-based Sanctuary Model is a trauma-informed and trauma-responsive care model for treating traumatised children and adults. Through creating an organizational culture that provides a cohesive and effective context, recovery from psychological and social traumatic experiences can then occur. It is an attachment-based organizational approach to change relationship patterns that have been damaging in the past and to create and sustain healing relationships. The team studied the Four Pillars of the Sanctuary Model: Shared Knowledge, Shared Values, Shared Language and Shared Practice. The S.E.L.F. (Safety; Emotions; Loss and Future) model builds recovery for the complex problems presented by trauma survivors through psycho-education, experiential practice, modeling and therapeutic intervention.

CCTC has also arranged for the team to participate in sharing by parents and caregivers who have completed their Filial Parenting Program that equipped parents/caregivers with skills (such as empathic listening, positive talking, use of praises) to improve family-child bonding. Guided by the principles of 4Rs + 2Ss – **R**espectful communication, **R**ules,





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**Responsibilities & Relationship + Social Support & understanding Stress**, parents and caregivers learn to relate and interact with their children through play in a therapeutic and purposeful manner and to acknowledge their own limitations as a parent or caregiver.

Learning benefits to the team include understanding and management of intergenerational trauma such as unresolved grief and its effects on the individual and family. Other benefits also included dialogue on the organizational framework, and understanding stages and phases of implementing a Trauma-Informed Care Model for IMH, as a mental health institution.

## **B) NEW YORK**

Following a two-week team-based visit in Philadelphia, the IMH team, accompanied by a psychologist from the Ministry of Social and Family Development (MSF) was hosted at the NYU Child Study Center with a two-day visit at the Family Service of Rhode Island (FSRI).

The team met with the chief developer of the TST model, Dr. Glenn Saxe and his team, including Dr Adam Brown, at NYU to receive the overview of the TST clinical and organizational model; to study the implementation fidelity with applicability to IMH settings and to collaborate with community partners for improving trauma-informed care locally. The team left with better understanding of how TST is used to stabilize the child's emotional/ behavioural functioning and social environment; linking the appropriate services to cross manage and support the child and the family.

In Singapore, children who experience traumatic stress can re-experience trauma reminders and complex trauma in a myriad of settings including their immediate homes, kinship care, therapeutic group homes, schools and community settings. TST is designed to stabilize children who experienced emotional and behavioural dysregulations related to their trauma. This clinical model provides a fundamental approach to understanding the role of the social environment and identifying the triggers or the "cat hair" in the child's social environment that leads him/her to re-experience the trauma symptoms and emotional dysregulations.

TST is both a clinical model for the efficient and effective treatment of traumatized children and an organizational model for delivering services. It is designed to address a broad range of complex behavioural and emotional problems (i.e. high risk for self-harming, abscond, etc.) that children could have related to their trauma history. The team aims to implement a trauma-informed care service that is sustained over time, supported by the Department of Developmental Psychiatry within IMH service system.

## **C) RHODE ISLAND**

Site visits and meetings with various service staff members further informed the approaches used in implementing TST in their residential, home-based and foster-care programs, and the basis of improving the child's regulations, stabilizing the child's social environment and increasing stability in biological, foster or kinship/placements. The team further studied FSRI's community programs and observed their facilities first-hand. Both programs employ TST-trained staff who utilize trauma-informed principles in their practices.

## **Recommendations and Skills Applications**

Recommendations for best practice within IMH would be the application of the therapeutic interventions studied, strengthened by a supportive trauma and attachment-informed environment of care with individuals, groups, and



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families. In this way the team and staff at IMH would be able to provide effective healing of emotional trauma and resolving issues of abuse, loss and abandonment, and family dysfunction. The team would assist in building an organizational environment at IMH, that ensures the full range of trauma-informed principles, safety and predictability, and a sense of hope and accomplishment that follows regulating behaviours and healthy emotional, physical, social and mental well-being, for staff, patients and caregivers alike.

As TST is developmentally informed, the team aims to establish a collaborative group of professionals from the multi-disciplines (i.e. doctors, allied health professionals, community partner agencies including child protection services) to deliver improved trauma intervention for IMH patients with severe and complex emotional and behavioural problems related to their trauma history. A trauma-informed care practice, incorporating TST and the Sanctuary Model, thus addresses the risks of fragmentation and burn out of any service system through insufficient communication between departments and inadequate cross-systems service plans.

For child and adult patients and staff in IMH, the principle teachings and concepts of Sanctuary Model and TST can be applied to the areas of:

i) Enhancing Clinical Practices

Many of our patients who require IMH services bring with them complex backgrounds of crisis and trauma. It is therefore essential to increase awareness and skills in trauma-informed practices, especially since IMH is a tertiary psychiatric hospital.

ii) Training for professionals

To incorporate the theories of the two models into appropriate regular training modules to enhance the knowledge and clinical skills of mental health professionals, especially in the areas of managing complex risks and trauma cases.

iii) PTSD Clinic

IMH Department of Mood and Anxiety will be piloting a specialized treatment program for adult patients with PTSD. Interventions would be guided by trauma-informed practices and trauma-centered therapies.

iv) IMH Staff and Peer Support Programs

In addition to building up and strengthening our IMH's CH.E.R.I.S.H, an on-site peer support program, for Department of Developmental Psychiatry (DDP) and Staff Support and Assistance Program (SSAP), the team intends to incorporate the TST and Sanctuary Model in understanding our affected staff better and to be utilized as part of the core training for our peer supporters.

v) Creative and Expressive Therapies

IMH's newly developed creative and expressive therapies can be integrated within both the Sanctuary and TST models for managing complex trauma cases. These include Directive, Non-directive and Group Play Therapy, Music and Art therapy and Filial Play Coaching, which addresses the child/ parent relationship and attachment issues central to recovery from complex trauma.



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## **Conclusion**

The current priority for our team is to share with our colleagues the culture of trauma-informed care and to emphasize the need for everyone to be involved so that trauma symptoms could be identified early and addressed within the various systems (i.e. families, schools, clinics, hospitals, residential homes, foster care, social welfare settings), and not in silos.

Potential challenges would be getting every staff with direct and indirect patient contact to come on board and procuring the necessary buy-in for trauma-informed care practice within the institution. Presentations and sharing at appropriate platforms with senior management and the larger hospital would be critical, and so is the support from top-down. Funding through a healthcare service development program, for example, might be necessary to help set up specific trauma services in various disciplines in the future.

With positive results and outcomes (e.g. better patient outcomes, reduction in default-rates and restraint/assault rates, etc.), it is hoped that other departments and hospitals would become more receptive towards adopting the Sanctuary Model and TST in their practice.

Trauma-informed care addresses the gaps in knowledge in the effects and ramifications of traumatic stress, allows healthcare staff to appreciate the influence of triggers on clinical presentations, and guides clinical practices and approaches so as to better manage our patients' symptoms and behaviours. Similarly, healthcare staff can benefit from the trauma-informed approach as they are often also subjected to or have had experienced trauma in their course of work, be it through abuse or loss of patients to suicide or death.

Trauma-informed care hence targets not just the microsystem comprising patients, but also the meso- and macro-systems within healthcare, education and social welfare ministries. By starting a pilot program in a smaller clinical unit such as the child psychiatry department, we can study, analyse, refine and build on existing knowledge for subsequent introduction and implementation of trauma-informed care across all clinical departments within IMH.



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## **Listening, Participating, Sharing, Healing, Leading, and Advocating in Child and Adolescent Psychiatry**

Dr. Matthias Köster (Switzerland)

Imagine a child or an adolescent that is thoroughly listened to, nurtured, and respected.

Imagine a society that helps their children to have legal and political representation.

Imagine parents that integrate their children's needs into their family values and actions; that protect and support their children; and that quickly access community help in times of crisis, before costly and irreparable harm results.

Imagine teachers that truly listen and teach in the most reciprocal way and that nurture collaboration, creativity, pursuit of interests, and academic and social competence.

Imagine child doctors that take the time to listen very carefully; that collaborate with patients and families in decisions; and that individualize treatments.

Imagine health scientists that understand children's needs and that prioritize a social peace/mental well-being/brain-body civil science project over a more reductionist project.

Imagine medical students that are trained in sociology, politics, rhetoric arts and leadership; that listen to society; and that help society to achieve peace and social well-being.

In such an envisioned world, the child would be truly prioritized.

It is time for child psychiatrists to promote such a vision, because we have enough evidence to know why violation of children's rights is unacceptable and costly on a personal and societal level.

We need to focus on meaningful, purposeful actions that are grounded in our vision of what it means to live good lives. Most of us listen and observe effectively, engender trust, and demonstrate altruism in our patient care. We therefore can be credible leaders if we collaborate with other professionals in advocating for mental health and opposing various injustices, such as inadequate engagement of young patients, inadequate opportunities for their rehabilitation, and inadequate funding for needed research and services.

Drawing from psychotherapy practice, one may benefit from asking what might cause feelings of regret, and then realizing that failing to build adequate relationships might be an important missed opportunity. Child psychiatrists must be leaders who humbly and nonjudgmentally integrate diverse cultures and disciplines with a focus on improving quality. Child psychiatrists must also effectively apply scientific knowledge in a way that meets UN sustainable developmental goals

( [https://www.who.int/gho/publications/world\\_health\\_statistics/2018/en/](https://www.who.int/gho/publications/world_health_statistics/2018/en/) ). We can turn to youth for instruction and inspiration. We can respond with gratitude to Greta Thunberg's challenges to us.



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Child psychiatrists should advocate for equality, freedom, the rule of law, human rights, strength in diversity, and a public/private balance to insure adequate social support and assurance of well-being. In this regard, child psychiatrists can serve as interpersonal, informational, or decisional leaders; advance policy – which is the “art of the possible”; and promote solidarity and a sense of “we-ness” that optimizes children’s development.

Drawing upon skills in working with families, child psychiatrists can foster a participative process, promote a healing dialogue, and ultimately make better decisions about how resources can be optimally managed and about how mental illnesses should be optimally approached. Child psychiatrists must be humble, open to feedback, and transparent in their work.

If we act now and with commitment, we will not have any future regrets.





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## **Meeting report**

### **First Infant Parent Mental Health Workshops in Pakistan**



Dr. Muhammad Zeshan and Dr. Alexandra Harrison (USA)

Dr. Alexandra Harrison (Assistant Professor Harvard Medical School, Boston, MA, USA) and I (Dr. Muhammad Zeshan, Assistant Professor Rutgers New Jersey Medical School, Newark, NJ, USA) visited Pakistan for almost 10 days. We went to 4 cities (Karachi, Multan, Muzaffargarh, Lahore) and presented 13 workshops at 10 big academic institutes on infant Parent Mental Health in Pakistan.

During our workshops, we highlighted that stressful life events can impact brain development during pregnancy and infancy. Strengthening the parent-infant relationship can protect the baby from the effects of stressful environment. Furthermore, core competencies that require for child academic, social, and other future success start developing during pregnancy and the first few years of life.

We introduced various concepts including Dr. Ed Tronick's "Still Face Paradigm" and "Mismatch Repair", Dr. Selma Fraiberg's "Ghosts in the Nursery", Dr. Alicia Lieberman's "Angel in the Nursery", as well as the ACE (Adverse Childhood Experiences) Study. We tried to explain how parents can be the "ghosts in the nursery" when they repeat their own difficult childhood experiences with their children. We explained that the healthcare workers, nurses, and other child caregivers can be "angels in the nursery" by helping parents understand their baby language-behavior, and making their babies feel more secure through nurturing, kind, and loving behavior.

We did practical demonstrations of some of the NBO (New Born Observation) techniques on infants by showing their parents and healthcare givers in the audience how baby can protect his/her sleep from light or noise. We showed how an infant can communicate with caregivers by recognizing the mother's voice, gestures of communications like wanting to eat, sleep or play. We answered questions how postnatal depression can impact maternal-child interaction by showing them the Still Face Paradigm video, highlighting how even a minute of lack of responsiveness from mother could physically and emotionally dysregulated the child.



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Most of our workshops were well attended by nurses, residents and faculty from the departments of pediatricians, psychiatrists, obgyn-gynecology; psychologists, medical students, and some families. The audience asked many interesting questions regarding the role of infant parent relationship training in kids with significant medical comorbidities. We explained the importance of recognizing parents about “Magic moments” when parents may have successful interaction with their babies. For instance, showing mothers that their babies can still respond to their voice, or can protect his or her sleep with light or noise, or can respond to when she calls her baby name-so even small acts of kindness and understanding can help to cope with stress even in difficult situations. We elaborated that in caregiver-child interaction, 50% of the interactions were initiated by the baby. So even if the mother or caregiver doesn't belong to an affluent or well-resourced family, helping mothers or caregivers recognizing their babies' behavior could help them protect, nurture, and enjoy their interaction with their infants.

Along with the rich discussions, we build a lot of good connections with the faculty at each institution. We plan to collaborate with the local institutions by training the lady health workers, nurses and other healthcare professionals on infant parent mental health. We also like to write booklet highlighting various important infant parent relationship concepts. We hope to visit Pakistan regularly (may be annually or biannually) to continue our collaboration and learning from each other.





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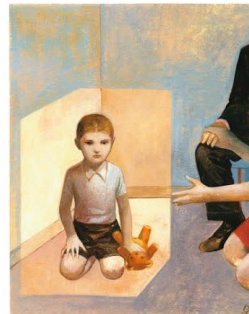
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## Book announcement

Bruno Falissard

# Soigner la souffrance psychique des enfants



**English title of the book:** Healing children's psychological suffering

**Description of the book by the author (Professor Falissard):** "A short book of about 200 pages that present clinical cases and that try to answer some essential questions like: do mental diseases really exist? Is there a difference between psychiatry and mental health? What is the job of a child and adolescent psychiatrist? What are the relative interest of neuroscience, statistics and psychoanalysis in child and adolescent psychiatry? What are the respective role and limitations of prevention, psychological treatments and medications?"





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## Future meetings

[www.iacapap2020.org](http://www.iacapap2020.org)



**IACAPAP 2020 SINGAPORE**

**24th World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professions**

20 – 23 Jul 2020 | Singapore

Starting at the Beginning  
- Laying the Foundation for Lifelong Mental Health

**Mark your calendar!**

Join our mailing list to stay updated on IACAPAP 2020



The International Association for Child and Adolescent Psychiatry and Allied Professions



Section of Child & Adolescent Psychiatry



INSTITUTE of MENTAL HEALTH  
National Healthcare Group



Singapore Psychiatric Association

**19TH WORLD CONGRESS**  
of the World Association for Dynamic Psychiatry (WADP)



**PEACE AND AGGRESSION**  
A SOCIAL CHALLENGE FOR  
PSYCHIATRY AND PSYCHOTHERAPY

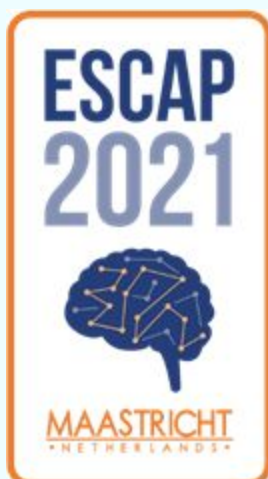
Berlin – Germany | 31th March – 4th April 2020  
Information and Registration: [wadpinternational.com](http://wadpinternational.com)



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19th International Congress  
of ESCAP Maastricht

**NETWORKS IN CHILD AND  
ADOLESCENT PSYCHIATRY**

27-29<sup>th</sup> June 2021

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