ISSUE #1, 2025

World Psychiatric Association, Early Career Psychiatry Newsletter

A Decade of Progress, A Future of Opportunities - Message from the Chair of the ECP Section

Dear Colleagues,

I am thrilled to greet you in this edition of the WPA Early Career Psychiatrists (ECPs) Section newsletter. This platform is a celebration of the accomplishments, milestones, and perspectives of ECPs worldwide. More than just a publication, this newsletter embodies our collective journey, resilience, and vision for the future of psychiatry.

Since its inception in 2015, the ECP Section has transformed from a small, enthusiastic group into one of the most dynamic and representative entities within the WPA. Established to encourage international collaboration, shared learning, and active participation in shaping global mental health, the Section is firmly grounded in the principles of equity, diversity, and inclusion. We are committed to ensuring accessibility, particularly for ECPs from low- and middle-income countries and underrepresented areas, guaranteeing that every voice is valued.

Throughout the years, our members have not only advanced institutional progress but have also experienced significant personal development. Many have embraced leadership roles in academia, clinical practice, and policy, demonstrating the lasting influence of investing in emerging leaders.

Since our new committee was elected last February, we have been actively working to continue this legacy. We initiated the Action Plan 2025–2028, conducted regular committee meetings, and enhanced our communication channels through the use of mailing lists and social media.

Here's a glimpse of our current initiatives:

- **Digital Advancements:** We established the WPA ECPs WhatsApp Community, featuring various global, regional, and thematic subgroups to facilitate immediate communication and support among peers. Additionally, our strengthened social media presence and improved registration processes are enhancing participation and visibility.

- **Collaborations:** In partnership with the Digital Mental Health Section, we hosted a webinar on ethics in mental health, designed by ECPs for ECPs. More exciting partnerships are on the horizon.

- **Representation:** The Section proudly participated in the WPA Regional Congress in Alexandria and the American Psychiatric Association (APA) Annual Meeting in Los Angeles. An ECP-focused session is also scheduled for the upcoming WPA Regional Congress in Ecuador.

- **Leadership Growth:** At the next WPA Congress, ECPs will take the lead in sessions like the WPA Quiz, Difficult Cases, the 3-Minute Competition, and symposia. ECPs will also mentor medical students and chair oral and poster presentations, showcasing their skills and leadership.

As we move forward, our dedication remains unwavering: to empower ECPs to lead, innovate, and advocate for the field. This newsletter serves as your platform —feel free to share your endeavours, experiences, and aspirations. Together, we are crafting a brighter, more inclusive future for psychiatry.

In this newsletter you can expect:

With warm regards,

Dr Lamia Jouini Chair,
WPA ECP Section Chair

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Introducing the WPA ECP Committee 2025-2028

Lamia Jouini (Chair) – *North Africa & Middle East (Zones 11–12)*
Leads the section, chairs meetings, and oversees strategic direction.

Alex Vicente Spadini (Co-Chair) – *South America (Zones 4–5)*
Supports coordination and decision-making.

Rick P. F. Wolthusen (Secretary) – *North America (Zones 1–3)*
Manages records, meeting minutes, and membership.

Katherine Tan (Newsletter Editor) – *Australia & New Zealand (Zone 18)*
Oversees content and publication of the section's newsletter.

Sara Medved (Social Media Coordinator) – *Eastern Europe (Zones 9–10)*
Manages online presence and social media engagement.

Ganesh Kudva (WPEP Coordinator) – *Asia (Zones 15–17)*
Oversees the World Psychiatry Exchange Program.

Tejil Morar (Conference Coordinator) – *Southern Africa (Zones 13–14)*
Coordinates ECP events at WPA conferences.

Fatma Swilem (Communications Coordinator) – *Western Europe (Zones 6–8)*
Facilitates internal and external communication.

Beyond Borders: How Global Connections in the WPA Shaped My Psychiatric Journey

While I spent time abroad during medical school, I thought of my career in psychiatry in familiar terms when I first entered the specialty: local hospitals, national conferences, and the professional circles of the American Psychiatric Association through membership and an APAF Public Psychiatry Fellowship. But stepping into the World Psychiatric Association (WPA) taught me that my identity as a psychiatrist—and the possibilities for growth—could be much larger. The WPA is a global association representing almost 150 psychiatric societies in 123 countries, bringing together more than 250,000 psychiatrists. Every APA member is, by default, also a WPA member.

I did not know what to expect when I first connected, as a third-year psychiatry resident, with the WPA during its 2022 World Congress in Bangkok. To my surprise, two of my abstract submissions were chosen for presentation. But what I found in Bangkok was more than a scientific audience; it was a vibrant community of psychiatrists from every corner of the globe: different health systems, challenges, and innovations. Some presentations looked at the same topic but from very different cultural and conceptual perspectives—how refreshing and relevant. Yet what surprised me most was how much we shared—a common dedication to improving mental health care and learning from one another.

The experiences that followed changed my career. I joined WPA's Early Career Psychiatry (ECP) Section as a member. I started interacting with early ECPs from around the world—these collaborations ended in international research projects that led to conference presentations and publications. During this year's World Congress in Prague in October, I will co-present a symposium about physician wellness with colleagues from Ecuador, Nigeria, and Lithuania. I also received a WPA Fellowship that supported my participation in last year's meeting in Mexico City, an experience that connected me with mentors and peers who became trusted collaborators—and friends. Through WPA activities, I've gained insights into how psychiatry adapts across vastly different cultural and economic contexts. These lessons continue to shape how I think about my work at home in the United States.

The WPA ECP Section has a lot to offer. Apart from collaborations, meeting inspiring colleagues from around the globe, and fellowships that enable World Congress attendance, the Section also offers an exchange program with host institutions in Tunisia, Nigeria, India, Iran, Nepal, Croatia, the United Kingdom, and the United States. The number of host organizations and applicants is ever-growing. Each placement offers a different and unique set of opportunities, from clinical practice over research to teaching and mentorship.

The Section also organizes get-togethers and scientific activities during the Congress, such as a competition that challenges ECPs to explain their research topics in three minutes or less; this event helps young psychiatrists improve their vocal pitch accuracy and learn how to capture an audience's attention. The competition's winners receive complimentary Congress registration and the opportunity to publish their research in a scientific journal.

Today, I serve as the WPA ECP Section's secretary and as the representative for North America, including Zone 1 (Canada), Zone 2 (United States), and Zone 3 (Mexico, Central America, and the Caribbean)—helping build bridges between and among ECPs across continents. I can say with certainty that being part of this global network has made me a better professional and a more open, creative, and resilient person. Our Section lives on participation and active membership. To join the Section, applicants need to be a WPA member and a current trainee in psychiatry or a recent psychiatry residency graduate (within seven years of graduation).

APA's affiliation with the WPA means that we are already part of something global. But becoming actively involved transforms that abstract connection into real, meaningful experiences. I encourage every North American ECP to take that step. Psychiatry knows no borders—and neither should we.

Dr Rick Wolthusen, M.D., M.P.P.

Rick is a staff psychiatrist at McLean Hospital and a psychiatry instructor at Harvard Medical School. He is a member of APA's Council on International Psychiatry and Global Health.

History of the WPA Quiz

The World Congress of Psychiatry (WCP) Quiz was first introduced at the 2020 World Congress as an innovative and interactive educational activity designed to enhance learning through fun, competition, and teamwork. Recognizing the value of engaging early career psychiatrists (ECPs) in preparation and facilitation, the inaugural quiz sessions proved a tremendous success, receiving overwhelmingly positive feedback from participants.

Held for the first time during the WCP 2020, the quiz format involved two sessions, each featuring two quizzes composed of ten carefully crafted questions. Beyond answering questions, participants benefited from detailed explanations supported by various didactic tools such as images, videos, and graphs, which enriched the learning experience. The quizzes focused on contemporary, theme-related topics like climate change and psychiatry, burnout among mental health professionals, and the relationships between migration and poverty and psychiatry.

Building on this initial success, the WCP Quiz was repeated virtually in 2021, maintaining its dynamic and interactive nature despite the ongoing pandemic. Themes included behavioral addiction during COVID-19, digitalizing psychiatry, mental health of healthcare workers, and abuse amid pandemics. The sessions allowed participants to join either individually or in teams, fostering not only competition but also real-time connection and collaboration across continents. The quizzes were organized through the dedicated efforts of an international team of ECPs led by Dr. Sami Ouanes and Dr. Lamia Jouini, who have been helming the quiz since its inception.

Following its virtual iterations, the WCP Quiz returned as a live event from 2022 onwards, further enriching the congress atmosphere by providing attendees with engaging and memorable learning moments. In 2022, the Quiz focused on different facets of empathy: from neurobiology to clinical implications and research. Each year, the quiz has continued to evolve, embracing new themes aligned with the Congress's focus and expanding its global reach.

In recent years, the Quiz has been hosted by a growing team of enthusiastic psychiatrists from many countries, covering a variety of cutting edge and unconventional topics such as the links between mental health and social media, artificial intelligence, and diet. For the 2025 edition Dr. Sami Ouanes and Dr. Lamia Jouini helm it again, with the addition of Dr. Hend from France and Dr. Nicholas Pang representing Malaysia and Italy as co-hosts. Their collaborative international efforts ensure that the WCP Quiz remains a highlight of the Congress, blending education, entertainment, and cross-cultural exchange.

The WCP Quiz has become a beloved feature for many congress attendees, who appreciate the opportunity to deepen their knowledge interactively, forge new connections, and enjoy a spirited competition. It stands as a testament to the power of innovation in medical education and the vital role of ECPs in shaping the future of psychiatry worldwide.

As the WCP community looks forward to future congresses, the quiz promises to continue growing in popularity, fostering a vibrant, engaging, and inclusive learning environment for all participants.

Dr Nicholas Pang, Faculty of medicine and health sciences universiti Malaysia Sabah Kota Kinabalu
Dr Hend Jemli, Psychiatry department A, Razi Teaching Hospital, Manouba, Tunisia.
Dr Sami Ouanes, MindWell, Kuwait Kuwait
Dr Lamia Jouini, Department of Psychiatr and Psychotherapy, Wallis Hosptital, Switzerland

WPA Exchange Program: All-India Institute of Medical Sciences

I had the honour to be shortlisted for the World Psychiatric Association Exchange Program for the All-India Institute of Medical Sciences (AIIMS) Guwahati, India. At the beginning of the program, I was challenged to reflect and think deeply regarding the program itself not only as an organic system but to the fundamental level of the existence of my presence in the land of Assam. This is an existential invitation to consider the reason of my motivation for the program: celebration of diversity. As an early career psychiatrist from the tropical country of Indonesia, I was confident enough that I will adapt easier in India, in terms of food and climate. I am aware of the possibility for language barriers, and other things to concern that needed to anticipate. However, along the way of my presence in the site the more I experience the dynamic within my internal working process.

Respect and Adaptation

Despite of the frequency of traveling, I learned that respect is a universal language. The foundation of this awareness comes from putting myself on the perspective of the third person. The pre-traveling preparation I have made is nothing compared to the experiences in the real setting. Adapting through the language does not warrant a smooth communication. An effective communication will blend very well with empathy, assertiveness and subconscious knowledge on your existence and your surroundings.

Embracing the Value of Friendship

The program itself does not limit to a formal academic activity. Instead, it open more opportunities to foster connection beyond curiosity. I learned that knowing more people is a formal way to adapt myself at ease in a new place. In addition, it extends the possibility to create more network from people to people. As if connecting the dots, participating in this program has inspired me to appraise the experience of meeting new people. The process itself is a dynamic way to understand human. At the same time, building up more common sense of adapting to the situation and stimulates the social cognition.

Learning through Reflection in Action and Participation

I have a different way of learning in a multi-cultural environment. Observing and immersing myself in the whole entire process. Learning is a very motivating way to implement creativity. During my stay in the AIIMS Guwahati, I allow myself to extend the capacity for looking beyond and thinking thoughtfully. I realize that psychopathology is manifested through the way someone perceive about their life, hope, and ambition in life. For this stance, everyone has shared the common value of humanity that life is the reflection of their value. Understanding this perspective empowers me to look beyond the psychopathology as the representation of humanity. It constructs the way I see mental disorder rather than just a disease, but a pathway to understand about the human itself.

I have another perspective regarding the pedagogic learning, in the sense putting myself together as the subject and object of learning. I learned that appraising the situation and analysing myself are the fundamental strategy to immerse myself in the active learning process. I really value and had the chance to exercise common sense of humanity, regardless language and nationality. Writing this report, I am grateful for the lifetime experience that has taught me about modesty and being present in the here and now. I thank the World Psychiatric Association – Early Career Psychiatric Section for developing such a meaningful program and for the most to the Department of Psychiatry AIIMS Guwahati, that I have considered as the laboratory of humanity and long-life learning.

WPA Exchange Program: From Aotearoa to Boston

With a six-hour layover in New York and a seventeen-hour flight back to Auckland, I've had plenty of time to reflect on my experience of the World Psychiatry Exchange Program. If you, like me, are at times prone to ambivalence and inertia, I implore you to read on. My aim is to demystify what the exchange involves and share the insights and benefits it offers in the hope of convincing you to apply.

I resolved to take part in the WPA exchange whilst swept up in the momentum of the New Year and a resolution to say 'yes' to more things. I was doubtful that my application would bear any fruit but was ecstatic when I was invited to visit McLean Hospital in Boston. With no small amount of apprehension, I bought a ticket to the U.S. and set off for the one-month excursion in mid-July.

Despite being the inaugural exchange at McLean Hospital, it was seamlessly executed. The exchange was facilitated by the Division of Psychotic Disorders in collaboration with the Office of Education Outreach. Whilst it may change in the future, the current rendition of the exchange is non-clinical, and in no way did this detract from the experience. A personalised schedule was developed, and I spent my time connecting with staff who share clinical interests. Most days involved meeting with a wide range of clinicians, leaders and researchers from McLean Hospital, Massachusetts General Hospital and Harvard University. I was struck by everyone's enthusiasm, kindness and eagerness to share ideas.

I gained insights into the open dialogue model employed by the psychotic disorder unit, spoke with staff who have delivered mental health care to Navajo Nation residents, and met with peer support specialists championing the WellSpace Program which supports young people who have had experiences with psychosis. I attended the resident weekly didactic teaching sessions, completed a one-day mental health first aid course, attended a La Colaborativa community event (an organisation supporting Latinx immigrants in greater Boston), and even went on a historic tour of the McLean campus.

What I have taken from this exchange has far exceeded my expectations. It was a privilege to gain an understanding of another health system. No amount of reading or attending conferences can compare to getting experience of a world class institution in the flesh. In many ways, this experience has conjured up more questions than answers that I will inevitably spend my career contemplating. Primarily, is the question of what an ideal mental health system looks like. This experience has further consolidated my (not particularly controversial) stance that global collaboration is essential if we hope to ever answer this question.

Whilst there are similarities between the New Zealand (NZ) and American systems and the challenges we face, there are also striking differences. McLean has enviable access to partial programs (intensive short-term treatment underpinned by group therapy and skill enhancement), specialised inpatient units and readily accessible neurostimulation and electroconvulsive therapy. The integration of research and clinical practice is noteworthy and seems to foster a trailblazing attitude to accessing newer treatments and a collective drive to add to the evidence base in the name of progress and improved outcomes. Whilst acknowledging some of the shortcomings of NZ mental health services (namely staff vacancies and insufficient resources), my appreciation of our universal public system, emphasis on community-based care and increasing focus on cultural safety has deepened. I have arrived at the same conclusion reached by many others who have been exposed to different health systems - each has their merits but can ultimately learn from the other.

I will forever be grateful to the wonderful people I met as a result of this exchange. The *manaaki* (a Māori concept loosely translated to generosity and hospitality) shown to me was beyond compare and greatly appreciated by a solo traveller setting foot in the U.S. mainland for the first time. Being a well-rounded exchange, there was ample time to live like the locals do, but also opportunities to sightsee and lean into the joys of being a tourist in the summertime. It is my sincere hope that the connections I have made will be enduring. If anything, this exchange has made the world of psychiatry feel a bit smaller and extended my peer group globally.

Now that I'm back in New Zealand and firmly settled into my usual routine, I'm keen to maintain the enthusiasm and momentum that this exchange has ignited. The next step is to present at the local journal club to not only recruit applicants for the next exchange, but also pitch the possibility of New Zealand acting as a host location.

*Ngā mihi (*thank you) to each and every person who made this exchange possible. I am particularly grateful to Dr. Rick Wolthusen for his tireless efforts in making the experience exceptional, Adriana Bobinchock and Dr. Dost Öngür for their instrumental roles in establishing the exchange program at McLean, the Royal Australian New Zealand College of Psychiatrists for funding via the Indigenous Financial Support Scheme, and Awhi Mātua community team for generously allowing me one month away from the service.

Photo: Dr Rick Wolthusen and Dr Grace Spratt

Dr Grace Spratt

Dr. Grace Rarangikura Spratt is a senior psychiatry registrar working in Tāmaki Makaurau/Auckland New Zealand. She is completing a Certificate of Advanced Training in Psychiatry of Old Age. Grace is of Te Ati Awa ki Whakarongotai, Ngāti Toa Rangatira and Ngāti Raukawa ki te Tonga descent. She recently spent a month in Boston as part of the WPA Exchange Program.

Bridging Borders: Psychiatry Amid Crisis and Solidarity

When I began my training as a psychiatrist in Amman, I never imagined that world events would so soon shape my practice. I was drawn to psychiatry by the belief that listening and empathy could mend minds. My mentors taught me the power of presence: a senior doctor once said, “Be a witness before you prescribe.” Those lessons guided me through late nights discussing cases and believing in each patient’s resilience. As war erupted in nearby Gaza, I watched a humanitarian crisis unfold. Families—neighbors to my neighbors—fled with trauma etched on their faces. In our clinics, anxiety and depression became foregrounded by newly arriving patients with nightmares of bombing raids and the loss of loved ones. I recall holding the hand of a teenage refugee who trembled at every loud noise. These moments humbled me; they reminded me that beyond the textbooks, I must adapt quickly. Statistics validated what I saw: an EMHJ review reported PTSD in more than half of Gaza’s children and high rates of depression among adults following the latest violence

Such numbers echoed in our consultations. We grappled with the ethical weight of listening to these stories night after night. Sometimes I felt exhausted and questioned if I was doing enough; studies show that local healthcare workers under siege experience burnout and secondary trauma from the constant strain

These facts made it clear that we were facing not just a clinical challenge but a profound human one—each of us on the front line of suffering. In these difficult times, I also experienced professional growth. My mentors urged me to find strength in solidarity. I joined online discussion forums where early-career psychiatrists from the Middle East, Europe, and beyond shared insights on trauma care. We exchanged tips. One colleague from Italy taught me a grounding technique for panic, while a psychologist friend in Lebanon described community support circles she organized. Through the WPA and APA networks, we learned together how to adapt psychological first aid to remote settings and share culturally adapted therapy tools across borders. Those conversations reminded me that we are not alone in this work. Psychiatry’s role now extends beyond our office walls. We are healers and advocates. As one APA leader recently wrote, psychiatrists are “best positioned to care for victims of conflict… and advocate for peace”

This speaks to the work in Jordan as well: our teams coordinate with NGOs to train teachers in psychological first aid, so that even in schools or camps, adults can recognize a child in distress. Like many colleagues, I have started speaking publicly about mental health. I explain why mental health care is part of healing after trauma and encourage community leaders to prioritize psychological wellbeing alongside basic needs. In public forums, I emphasize that seeking help is an act of courage, not shame. Today, I carry both hope and sorrow. Hope in the resilience I have witnessed: children who still laugh, communities that open their doors to strangers. Sorrow for lives shattered and the ethical dilemmas we face every day. But above all, I feel connected. Connected to the young doctor in Gaza returning to her clinic after an airstrike, and to a psychiatrist in Europe who just organized a fundraising webinar. As colleagues, we share our failures and small victories. We remind each other that every consoling word, every act of solidarity carries meaning and brightens the path forward. In the end, personal growth and global solidarity go hand in hand. My journey has taught me that when conflict breaks hearts, we must bind them together, heart to heart and country to country. The crisis in Gaza has challenged me, but it also affirmed why I chose this profession: to listen, to understand, and to stand with those in pain. As early-career psychiatrists, we carry the torch of empathy into the darkness, knowing that together, we can light the way toward healing.

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Dr Mohammad Abu Slaih

Your Guide to the ECP Experience at WCP 2025 in Prague

Dear ECP Members, ECP Alumni and allies,
Are you attending the *25th World Congress of Psychiatry of the World Psychiatric Association* in Prague from **October 5–8, 2025**?

What's Happening in the ECP Section?
The ECP Section has curated an exciting program tailored for Early Career Psychiatrists. It's a space to **connect, exchange, and thrive** - with sessions designed to spark learning and build community.

- **See the WCP program at a glance here**

WCP Prague opening ceremony and welcome reception

- **Sunday, October 5 | 18:00–19:30 PM**

Join us for the WCP opening session and welcome reception to get a first glimpse of the congress's program and congratulate this year's fellowship winners. Enjoy the welcome reception and meet the WPA community.

Medical Students session

- **Monday, October 6 | 11:45–13:30 AM**

Participate in a workshop designed for medical students to share your experiences and professional journey while serving as a mentor for the duration of the workshop.

WPA Quiz

- **Monday, October 6 | 13:30–14:30 PM**

Join a team of passionate young professionals from around the world for a fun, interactive quiz session. Test your knowledge on trending psychiatric topics - and win a prize!

Difficult Cases Sessions

- **Monday, October 6 | 9:15–10:15 AM**
- **Tuesday, October 7 | 9:15–10:15 AM**

Real-world, de-identified clinical cases presented by ECPs, followed by dynamic discussions with international experts and the audience. These sessions foster collaborative learning in an informal, stimulating setting. The cases this year will focus on psychosis and mood disorders in child and adolescent psychiatry (with discussant Dr. Lachman) and on catatonia (with discussant Prof. Northoff).

3-Minute Competition

- **Tuesday, October 7 | 16:30–17:30 PM**
- **Wednesday, October 8 | 09:15–10:15 AM**

ECPs will present their research, ideas, or clinical insights in just 3 minutes! A fast-paced, high-energy session to showcase innovation and clarity. Prizes await the most compelling presentations.

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Become a chairperson for oral and short oral poster sessions
Chairing a poster session is a great opportunity to engage with innovative research, support fellow professionals, and enhance your leadership and visibility within the global psychiatric community.

- **See the remaining sessions available here and write your name in front of your sessions of interest before August 31**

ECP Section 10th Anniversary Celebration
Tuesday, October 7 | 17:30–19:00 PM
In 2025, the ECP Section proudly celebrates **a decade of milestones and meaningful progress**. This special gathering will bring together ECPs, alumni, and WPA leaders - past and present - for reflection, connection, and celebration (see full program here).

ECP Section Dinner
Tuesday, October 7 | 19:00–21:30 PM
Join us for a cozy dinner at a local Czech restaurant, just a short walk from the WCP venue. Enjoy traditional food and drinks in great company! The restaurant can accommodate up to 40 guests. Priority will be given to ECPs and alumni. Family members and friends are welcome to join if there are available spots on the dinner date. If you need to cancel, please inform us as soon as possible so we can offer your spot to someone from the waiting list.

- **Registration and more info about the dinner here** (limited to 40 seats that will be allocated on a first-come, first-served basis)
- **More info about the restaurant here**

If you do register but need to cancel (even last minute), kindly send us an email to wpa.ecp.section@gmail.com using "cancellation WCP dinner" as the subject.

Stay Connected
Join our **WCP Prague WhatsApp group** to stay updated and connect with fellow ECPs throughout the congress.

- **Join the WCP Prague WhatsApp group here**

Looking forward to seeing you in Prague!
Warm regards,

Dr Lamia Jouini- ECP Section Chair
On behalf of the ECP Section Committee 2025-2028

WPA Regional Congress - Ecuador November, 2025

Dear Colleagues,

It is my great pleasure to extend this warm invitation to join us at the World Psychiatric Association (WPA) 2025 Regional Congress, to be held in Quito, Ecuador, from November 14 to 16, 2025.

This event will bring together renowned experts, early career psychiatrists, and mental health professionals from around the world to exchange knowledge, foster collaboration, and advance the field of psychiatry.

Under the theme “From the middle of the world towards a transformative Psychiatry” the Congress will feature keynote lectures, symposia, workshops, and networking opportunities designed to enrich clinical practice and research.

Your participation will be invaluable in making this Congress a vibrant platform for learning and connection.

For more information about registration, the scientific program, and accommodation, please visit the official website of the Congress (https://wparegional2025.org/).

Warm regards,

Dr Andrés Román Jarrín (MD, MS)
Member of the Organizing Committee, the Scientific Committee
The Early Career Psychiatrists (ECP) Committee – WPA 2025 Regional Congress

https://wparegional2025.org/

Reflection on past WPA conference experiences and impacts

I had the opportunity to take part in the past World Psychiatric Association 2023, which has been enriching to my career development. This has led me to interact with experts from all over the world.

I was able to join the Early Career Psychiatrist Section. It provided me possible opportunity to present my research, participate in scientific discussions, and present a difficult case. This has enhanced my visibility and created an opportunity to publish the research right after the congress.

I was able to join the WPA eating disorder task force with the invitation of Dr. Hubertus Himmerich and the WPA substance disorders task force. Joining the WPA eating disorder task force has provided me with the opportunity to collaborate on research projects that led to the publication of a commentary in the Lancet journal with Dr. Hubertus Himmerich. Furthermore, it led to taking part in the consensus Statement on Candidate Biomarkers for Anorexia Nervosa with colleagues from WFSBP Task Force Eating Disorders.

These experiences have enhanced my communication, presentation skills, enhanced my network, and collaborative learning from experts. Taking part WPA congress has contributed to the growth of my career and inspired me to be engaged in future WPA activities and collaboration.

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Breaking Barriers: Why Early Career Psychiatrists Must Champion Equitable Mental Health Care for Minority Children

As early career psychiatrists, we are uniquely positioned to influence the future of mental health care. Around the world, children from Black, biracial, and minority ethnic (BBME) backgrounds face significant barriers to accessing urgent mental health support. In the UK, across African nations, and globally, recent research has shown that stigma, cultural misunderstanding, and systemic inequities often delay timely intervention, placing already vulnerable young people at further risk.

Understanding the Challenge

BBME children commonly encounter three major obstacles in accessing care:

Stigma and Cultural Mistrust:

In many communities, mental illness remains a taboo subject. Families may avoid seeking help due to fear of judgement, shame, or mistrust of services. This silence often prolongs suffering and increases the risk of mental health crises.

Structural Inequities:

Lengthy wait times, fragmented services, and systemic bias make access more difficult for minority families. In some settings, the journey to receive support is more complex and takes significantly longer for BBME children than for their peers.

Lack of Representation in the Workforce:

There is a shortage of mental health professionals from diverse backgrounds. This gap contributes to communication challenges, reduced trust, and a lack of cultural understanding within services.

Why ECPs Must Lead

Early career psychiatrists can and should be at the forefront of driving meaningful change. Our roles as clinicians, educators, and advocates position us to:

Innovate: Develop new, accessible models of care such as school-linked mental health teams or digital outreach services for hard-to-reach families.

Advocate: Influence policy and funding decisions to support culturally responsive services. The Royal College of Psychiatrists encourages efforts to promote inclusion, representation, and equality in care.

Educate: We must ensure that training in cultural humility, anti-racism, and inclusive practice is embedded within psychiatric education. The NHS advocates for a more inclusive and culturally aware mental health workforce, recognizing that such training improves patient trust, engagement, and outcomes especially among underserved populations.

Practical Actions for ECPs

- Co-design Services with Communities: Collaborate with BBME children and their families to ensure services reflect their needs and values.
- Simplify Access: Advocate for streamlined referral processes and integrated community hubs to reduce delays and improve engagement.
- Use Your Platform: Share findings, clinical audits, and stories from practice that highlight service gaps and propose actionable solutions. Even small contributions can inform broader change.

A Collective Responsibility

The mental health needs of BBME children cannot remain on the periphery of psychiatric reform. As emerging leaders, we have a professional and ethical duty to champion equity within our services. This begins with self-reflection, continues through direct action, and is sustained by partnership with the communities we serve.

Whether through mentoring, reviewing your service's referral pathways, or joining advocacy networks such as the WPA Task Force on Cultural Psychiatry every action contributes to a more inclusive system.

Health equity is not a future ideal. It is a current obligation, and it begins with us.

Beyond the Clinic - Building Skills, Confidence, and Community Through Medical Education: A Personal Reflective Story Spanning Two Decades

From the very start, learning and teaching have felt inseparable for me. As a teenager, I was a top-performing student, but what brought me the most joy was not my own grades - it was helping classmates grasp something they had been struggling with. Whether it was explaining a tricky maths problem or simplifying a science concept, I loved seeing their faces light up with understanding. That feeling of connection, of empowering someone else, has been the quiet, steady thread through my life.

In school, this began with GCSEs, where I excelled academically but naturally became the person friends would turn to before exams. A-Levels deepened that habit - I ran informal tutoring sessions for peers, especially in English, Mathematics, and Science. It gave me my first taste of teaching not just for results, but for confidence.

Medical school initially pulled me towards surgical specialties - particularly General Surgery and Obstetrics & Gynaecology. My love for painting, jewellery making, and embroidery had given me a precise hand, and surgery felt like the natural extension of that skill. However, a personal experience with my grandfather - someone I truly admired and loved - changed my course. He struggled with low mood, poor self-esteem, and health-related anxiety. The stigma around mental health meant he never sought formal support, and I found myself acting as both his granddaughter and therapist during my undergraduate years. Our conversations about symptoms, diagnoses, and medication effects became my first lessons in patient-centred care. He once told me that, as a third-year medical student, I explained his medication better than his doctor - and that moment planted the seed for my future in psychiatry.

After graduating in medicine, life changed on every front - marriage, motherhood, and balancing personal with professional commitments. Moving to the UK was exciting yet daunting. I navigated IELTS, PLAB, GMC registration, and my first NHS role while adapting to a new healthcare culture. I discovered that the best way to revise was by teaching - forming study groups, explaining topics to colleagues, and creating spaces where international medical graduates could support each other.

When I began Core Psychiatry Training in East London after MSRA exams and interviews in 2020, I sought out every opportunity to teach. My first formal step was becoming an OSCE examiner for final-year medical students at Barts Health NHS Trust, followed by helping deliver psychiatry simulation sessions. I also supervised medical students on psychiatry placements, guiding them through patient interactions, reflective practice, and case presentations, helping them see the human side of mental health care. Soon after, I joined Hackney Carers' Caring Conversations project, giving monthly talks on common mental health conditions. Here, I learned how to adapt complex medical language for carers and community members - keeping it clear, empathetic, and relevant.

In 2025, I achieved the Fellowship of the European Board of Psychiatrists and passed my MRCPsych exams - a turning point. Alongside my friend and colleague, Dr Steve Calvosa, I co-founded TresMentis, an educational platform now with over 330 members. We offer weekly CASC practice, UK psychiatry orientation, and mentorship for IMGs - always in a supportive, feedback-driven environment. Many participants have shared that our sessions built not only their knowledge but also their confidence, providing a safe space where they felt heard and supported.

Building on this momentum, I became Programme Lead and Session Chair for the British Indian Psychiatry Association's PsychTalk series, helping early career psychiatrists and IMGs refine consultation skills, build rapport, and navigate difficult conversations. The mix of OSCE-style practice with real-world communication reinforced my belief that good teaching is about more than facts - it is about equipping people to face challenges with clarity and compassion.

I have now commenced Specialty Training in South London. My next goal is to complete a Postgraduate Certificate in Medical Education and secure a formal teaching role with undergraduate medical students.

This journey has not been a straight line - it has been a winding path marked by personal milestones, professional shifts, and a constant thread of teaching. Along the way, there were doubts, roadblocks, and tears - moments when I wondered if I was on the right track. But persistence and passion have a way of finding their place, and things often worked out in ways I could never have planned. Balancing marriage, motherhood, and career changes has taught me that timing is personal, and progress is not a race. Your story is your journey - the right opportunities will fall into place if you work hard, stay patient, and remain open to change.

For me, teaching is more than imparting knowledge - it is about building confidence, sparking curiosity, and creating safe spaces for learners to grow. Whether guiding a carer through understanding mental health, helping a trainee master a difficult OSCE station, mentoring a colleague through their transition into the NHS, or teaching medical students on placement, my aim is always the same - to make learning clear, relevant, and empowering.

I owe much of what I have achieved to my family, friends, mentors, and teachers - their encouragement has been the constant foundation beneath every step. Whatever the future holds in psychiatry and medical education, I hope to keep building communities where skills, confidence, and compassion grow together.

https://www.bipa.org.uk/event-details/master-the-art-of-clinical-conversation-from-exams-to-everyday-practice-session-4

Loneliness in the Era of Connection

We are living in era of high speed internet, AI, ChatGPT, 24x7 connection, online mode always on- and yet an era of broken families, trust issues, no friends and loneliness disguised as being too busy. No it's not a description of an unsocial person or an introvert with absent social life. This is the everyday reality of a lot of youth seeking Psychiatric consultation today in India. As a Psychiatrist working closely with youngsters in their teens & twenties, it's appalling to see when Chatgpt becomes your best friend or a spider on the bathroom wall becomes somebody you talk to about your deepest fears. Consider this in a country full of almost 1.5 billion people - a country that prides itself on it's closely knit families and an exceptionally low divorce rate. These stories once casually discussed as possible threats of prolonged screen time & the adverse effect of social media in academic circles & Psychiatry conferences has become a common parlance among India's youth today.

In the last 1 month I've heard from my patients how they use Chatgpt as Therapist, Best friend, Life coach & Girlfriend. One of my patients got diagnosed as a case of Gender Identity Disorder by Chatgpt. The clueless 19 year old was relieved when I gave him the diagnosis of Anxiety Disorder and told him to take a break from his phone and talk to ' real people' for a while. This boy was lucky enough to be surrounded by such caring & aware friends who brought him to a Psychiatrist when they noticed a behavioural change affecting his mood, lifestyle & career. Not everybody will be so lucky.

While everyone is glued to their phones, sometimes we can never know what exactly they are going through when Depression is masked as being bored or Anxiety masked as being a workaholic. There is an interesting observation though- these same group of boys can sit for hours talking about College life in a face to face setting as in a Psychiatrist's clinic - telling me about tiny details relating to their family, friends & future with an air of laughter and joviality so characteristic of youngsters.

What is the missing ingredient that makes this opening up not possible infront of their closest people? Have we failed to cultivate real connection ? Has AI & Chatgpt become that 'judgement free zone ' that we were looking for in people? What prevents us from making friends in today's age? These are some of the daunting questions we as society need to look into before such incidents become 'normal'.

Dr Pubali Chaudhuri

Dr Pubali Chaudhuri is a Consultant Neuro-Psychiatrist working in Kolkata with 6 + years of experience. They have completed an MBBS with Honours (WBUHS) and MD Psychiatry (SSKM), DCMH (NIMHANS Bangalore).

Psychotherapy Training in Psychiatry: Early Career Psychiatrists' Interests and Opportunities

Psychotherapy is a crucial part of mental healthcare. Including evidence-based practices in treatment guidelines underscores the importance of basic psychotherapy skills in psychiatric training. The World Psychiatric Association (WPA) suggests that psychiatry training should include training in basic psychotherapy knowledge in the first year, advanced psychotherapy skills in the second year, and the ability to provide effective medium- to long-term psychotherapy as core competencies [1]. Over the past 25 years, research into how well training programs and opportunities for early-career psychiatrists (ECPs) meet these aims indicates that psychotherapy training opportunities are somewhat limited.

In our recent systematic review, we aimed to explore existing data in the literature regarding the interests and opportunities of ECPs in psychotherapy training [2]. Included studies were from Europe (24, 50%), the Americas (12, 25%), Western Pacific (6, 12.5%), South-East Asia (4, 8.3%), Eastern Mediterranean (1, 2%), and Africa (1, 2%), with a total of 7,196 participants. We found that psychiatry trainees and ECPs exhibit a high interest in psychotherapy, which is consistent across different years and healthcare systems globally. However, opportunities for training were considered mostly inadequate. Despite many ECPs advocating compulsory psychotherapy training in psychiatry, it was not consistently included as a required competency in curricula, except in a few high-income countries. Even where training was mandatory, significant variations in implementation across institutions and a lack of standardized education were common. Cognitive behavioral therapy and psychodynamic psychotherapies were the primary modalities offered during psychiatry training. Overall, our results confirmed that early-career psychiatrists are motivated for psychotherapy training, but resources seem limited. Improving psychiatrists' access to evidence-based, culturally adapted psychotherapy training is essential. Educational activities offered by not only training institutions, but also professional organizations can play a key role in supporting ongoing professional development. For that matter, we stress the importance of inclusive approaches to psychotherapy training, notably through the efforts of professional organizations such as the European Psychiatric Association (EPA e-Learning Platform [3]), the European Federation of Psychiatric Trainees (EFPT Psychotherapy Guidebook [4]), the World Psychiatric Association (WPA Psychotherapy Learnbook [5]), and the World Federation for Psychotherapy.

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Dr Selin Tanyeri Kayahan

Letter to Editor Journal Club. From critical appraisal to publication: A Trainee-Led Collaborative Project

Background

Opportunities for academic writing and publication can be limited for Core Psychiatry trainees, despite the importance of critical appraisal emphasised in the training curricula. The Letter to Editor Journal Club was established in early 2025 to address this, initially by Dr Sophie Flood (in her role as Higher trainee in General Adult Psychiatry), with leadership roles then taken on by Core trainees. This peer-led platform encourages reflective engagement with psychiatric literature and provides a structured pathway to publication in a peer-reviewed journal.

Aims

- To develop critical thinking when reading journal articles and academic writing skills
- To provide a supportive structure for peer mentoring, editorial feedback, and collaborative writing
- To allow for interest in academia early in psychiatry training
- To align academic activity with competencies in evidence-based medicine, reading articles pertaining to clinic experience
- To obtain points for higher training application

Methods

Recent relevant articles are selected by a trainee committee and distributed among subgroups for critical review. Trainees are encouraged to read the article prior to meeting with their subgroup on Teams for an hour. A designated 'scribe' (first author) in each subgroup leads the writing process; they consolidate and gather ideas that come up during discussion. The document is shared for editing by all members of the subgroup. The draft is refined over the span of a few weeks and reviewed by a higher trainee before submission. The letters are prepared in line with the guidance from Royal College of Psychiatrists Portfolio eLetter Instructions for Authors.

Results

5 structured sessions have been held approximately monthly, with 23 trainees currently involved — a fourfold increase since the first session. 5 higher trainees have supported in mentoring roles. 11 articles have been discussed, leading to 10 publications in 2025 across multiple journals, with 9 different lead authors. Topics have spanned pertinent themes in psychotherapy, psychopharmacology, academic psychiatry, sociocultural psychiatry, and more. The Journal Club has mainly engaged Core Psychiatry trainees, with growing involvement from GP trainees and foundation doctors. Formal feedback highlights gain in writing skills, confidence, and peer collaboration. We aim to link this model to the local teaching Journal Club in the future

Conclusion

The Letter to Editor Journal Club is a sustainable model for fostering academic development in training. By supporting trainees through each step of the publication process, it allows them to become active contributors to academic world of publication in peer-reviewed journal and bridges clinical experience with scholarly engagement



Cannabis and Psychosis: The Chicken or the Egg,which comes first ?

The question of whether cannabis use leads to psychosis or whether individuals with psychosis are more likely to use cannabis has long puzzled researchers and clinicians. This dilemma—akin to the age-*"chicken or the egg"*; question—has significant implications for mental health policy and treatment. While numerous studies suggest a strong association between cannabis use and psychotic disorders, the direction of causality remains debated (1) .

High-potency cannabis strains with elevated tetrahydrocannabinol (THC) content have been linked to increased psychosis risk (2) . THC, the psychoactive component of cannabis, affects the brain's dopamine system, which is also implicated in psychotic disorders. Longitudinal studies indicate that early and frequent cannabis use, especially during adolescence, may increase the likelihood of developing psychotic symptoms later in life (3,4) . However, not everyone who use cannabis develop psychosis, suggesting that other factors such as genetic vulnerability and environmental influences, such as childhood trauma, urban living and social stressors, play a role (5–7) .

On the other hand, some researchers argue that individuals with emerging psychotic symptoms may use cannabis as a form of self-medication (8) . Anxiety, paranoia, and social withdrawal—common prodromal symptoms of psychosis—might drive individuals to seek relief through cannabis. This perspective suggests that the observed association between cannabis and psychosis may partially, be due to reverse causality. Additionally, individuals with psychosis may have underlying cognitive and behavioral traits that make them more prone to substance use (9,10) .

Mendelian randomization and longitudinal twin studies further provide insight into the reverse causality argument – whether individuals with psychosis are more likely to use cannabis. These studies use genetic data to assess causality more rigorously. Gage (2019) examined multiple lines of evidence, concluding that both genetic vulnerability and environmental factors contribute to the observed link between cannabis use and psychosis. Such findings suggest that rather than a simple cause-and-effect relationship, cannabis use and psychosis may be interconnected through shared genetic and environmental risk factors (11) .

Neurobiological studies enhance our understanding of this relationship. While Murray et al. (2017) provides insights into neural mechanisms, newer neuroimaging and dopamine-related research further explore cannabis's effects on the brain. Not all cannabis is the same—most studies focus on THC, but cannabidiol (CBD) may have protective effects against psychosis. Bhattacharyya et al. (2018) found that CBD may counteract some of THC's harmful effects, highlighting the need to differentiate between cannabinoids in research.

Early intervention is crucial in managing psychosis and substance use disorders. Studies indicate that prompt treatment—combining antipsychotic medication, cognitive behavioral therapy (CBT), and psychosocial interventions—improves outcomes, reducing symptom severity, enhancing daily functioning, and lowering relapse rates (12) . Programs like coordinated specialty care (CSC), which integrates medical treatment, substance use management, and family support, have proven effective for first-episode psychosis (13) . Addressing cannabis use early in individuals at high risk for psychosis may prevent symptom progression and improve treatment adherence (14) Rather than a one-way causal link, the relationship between cannabis and psychosis is likely bidirectional. Cannabis use may contribute to psychotic symptoms, while individuals with psychosis may also be more likely to use cannabis (11,15) . Shared genetic risk factors between cannabis use and schizophrenia suggest both phenomena might stem from common biological vulnerabilities (7,16) .

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Tethered or Caught in a Web? Reconsidering the Roots of Suffering in Mental Health and Substance Use

We recently read Dr. Mark Earnest's poignant piece, Tethered, published in the New England Journal of Medicine (1), which we found both touching and unsettling. The case of Jack—a young man struggling with alcohol use disorder while caring for his ailing mother—reveals not only the tragic intersection of personal suffering and social abandonment, but also the limitations of our current clinical frameworks. Dr. Earnest captures the impossible bind Jack faces, presenting it as a choice between personal progress and familial duty, between self-preservation and care for others—a story of failure when sacrifice is chosen. The narrative is haunting and painfully familiar to those of us working in mental health. However, we would suggest that this framing may present a false dichotomy. While Jack's situation is undeniably a dilemma, other solutions—more humane and systemic—do exist.

The dominant biopsychosocial model in psychiatry provides a valuable and humane structure for clinical formulation (2). Yet, in stories like Jack's, even this model feels incomplete. What it fails to fully capture are the broader existential, spiritual, and societal dimensions of distress—the layers of meaning, purpose, and context that frame an individual's suffering. Psychiatry, if it is to be truly person-centred, must go beyond treating symptoms and even beyond integrating biological, psychological, and social domains. It must also address the existential questions patients carry: Why me? What is my place in this world? What happens when I cannot carry the weight of others anymore?

Jack's predicament is more than a case of addiction or caregiver burnout—it is a quiet indictment of a society that too often privatises suffering. When public systems fail—when elder care is inaccessible, when addiction services are siloed or under-resourced, when community support is lacking—it is individuals like Jack who are forced to absorb the consequences. They are asked, implicitly or explicitly, to trade their mental health for the well-being of those they love.

This is where an existential lens becomes vital. Existential psychiatry, grounded in the works of Viktor Frankl, Rollo May, and Irvin Yalom, among others, teaches us that meaning-making is central to human resilience (3). But meaning cannot flourish in a vacuum. Jack may have found meaning in caring for his mother, but meaning without support becomes martyrdom. He was not only tethered—as Dr. Earnest suggests—but entangled in a social web that failed to hold him.

From a public health standpoint, Jack's story is a predictable outcome of structural neglect. The burden of unpaid caregiving disproportionately falls on individuals with few resources. According to the AARP, over 38 million people in the U.S. provide unpaid care to adults, often at great cost to their own physical and mental health (4). These invisible caregivers are at higher risk of depression, substance use, and social isolation. When addiction arises in this context, it is not simply a disease—it is a cry against overwhelming strain, a coping strategy in the absence of alternatives.

Addressing such cases requires more than empathy; it requires systemic accountability. What if Jack had access to a robust social safety net? What if home health services, caregiver relief, and community-based addiction treatment were readily available and destigmatised? What if we invested in wraparound models of care that integrated mental health, primary care, social work, and spiritual support?

Psychiatry must reclaim its role not only as a healing profession but also as a moral one. The right to health, as recognised by the World Health Organisation and enshrined in international human rights law (5), is not limited to the availability of medication or clinic visits. It encompasses access to the social determinants of well-being—housing, education, food security, and social support. When these are absent, even the best psychopharmacological care can feel like a bandage on a deep wound.

In our work as early career professionals and students navigating psychiatric and existential care, we have observed that suffering often emerges not from pathology alone, but from a profound sense of disconnection—from others, from one's own values, and from a meaningful future. Jack's story underscores the need for psychiatry to integrate the existential with the systemic. This means asking not only, "What is the diagnosis?" but also, "What kind of world allows this person to fall through the cracks?"

Ultimately, the path forward is one of integration. We need a psychiatry that honours the individual's inner life while also confronting the external structures that shape it. We need training programmes that teach future psychiatrists to think existentially, politically, and ethically. And we need public policies that reflect the truth Jack's story so painfully illustrates: that no one should have to choose between recovery and responsibility in a just society.

True healing, as we see it, lies at the intersection of personhood and policy. It is here—between the inner voice that asks for meaning and the outer world that must respond with care—that the future of psychiatry must be forged.

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The Enduring Enigma of Deficit Schizophrenia

"My face I'll grime with filth
Blanket my loins, elf all my hair in knots
And with presented nakedness outface
The winds and persecutions of the sky."
- Edgar, Act 2, Scene 3, line 1.

These famous lines from Shakespeare's King Lear have etched the image of Edgar disguised as the Bedlam beggar Poor Tom deeply in the minds of audiences for centuries. His description of schizophrenia, while dramatized, is on point, displaying the self-neglect seen in severe deficit schizophrenia. Deficit schizophrenia is a subtype of schizophrenia with especially enduring symptoms of "deficits" in emotional expression and general motivation. This group of symptoms is termed negative symptoms, and broadly affect five domains including motivation (avolition), the ability to feel pleasure (anhedonia), social withdrawal (asociality), reduced verbal output (alogia) and diminished emotion (affect) (1). On the other end of the dichotomy, people with schizophrenia also exhibit active psychotic symptoms, known as positive symptoms. An example includes auditory hallucinations, where Edgar proclaims "The foul fiend haunts poor Tom in the voice of a nightingale." Delusions and disorganized, bizarre behavior are also positive symptoms. In the history of our understanding of schizophrenia, negative symptoms were initially cornerstone features described. Unfortunately, past decades have seen a rise in emphasis on positive symptoms and gradual neglect of negative symptoms. It is a pity that centuries later today, we are none the wiser as to its etiology and treatment.

It may come as a shock to the uninitiated to realize that there are currently no proven treatments for negative symptoms in schizophrenia, despite decades of research and the beacon of modern science. Research over the years has focused on glaring positive symptoms, which are more likely to attract attention, and often translate into increased hospital visits and admissions. The landmark discovery of chlorpromazine in the 1950s spurred excitement when there finally seemed to be a cure for "insanity", as it was known through the ages (2). Subsequent years tipped into the frenzied search for medications to treat positive symptoms. Following chlorpromazine, haloperidol was discovered and the dopamine hypothesis began to take hold. This hypothesis now forms the mainstay of understanding of positive symptoms, and is the basis for use of antipsychotics (dopamine antagonists) (3). Barely eight years after the discovery of chlorpromazine, clozapine was discovered in 1958. This drug is now the gold-standard therapy for treatment-resistant schizophrenia, although it was introduced later and involved a grapple with side effects (4). Today, we talk about newer (second generation) antipsychotics with fewer side effects, but the lack of progress in treatment of negative symptoms is stark.

Antipsychotics are unable to treat innate (primary) negative symptoms arising from schizophrenia. They may only treat secondary negative symptoms indirectly, by targeting positive psychotic symptoms causing them. For example, reducing auditory hallucinations endorsing persecution may calm patients, so they may be more willing to engage with others, improving motivation and sociality. The core management of negative symptoms today involves extensive rehabilitation, alongside social skills training and cognitive-behavioral therapy. These are inexact methods and target symptoms rather than underlying psychopathology. Yet, they are the best we have in practice to improve functional outcomes. Some have reported success in improving certain negative symptoms with transcranial magnetic stimulation of the brain, but this is not well-established (1).

The lack of treatment for innate negative symptoms can be attributed in large part to our lack of understanding of underlying mechanisms. At its core, we are divided – is it related to neurodevelopmental or neurodegenerative processes? Does it mainly stem from neurotransmitter imbalances? Patients with expressive deficits at times manifest impaired sensory and motor integration, suggesting neurodevelopmental abnormalities (1). Smaller volumes of frontal lobe white matter in the brain have also been associated with a higher burden of negative symptoms (5). Reduced dopamine in the frontal lobe and mesolimbic regions (the control center for reward, emotion and motivation) has been linked to the development of negative symptoms. Another neurotransmitter, glutamate, has also recently been implicated (6). It is unlikely that a single hypothesis accounts for negative symptoms, given the heterogeneity of presentation. Several concomitant processes are probably at play, and we are far from identifying a unifying hypothesis.

In essence, the origins of negative symptoms remain elusive, and we are direly in need of greater understanding, to develop targeted treatments. Negative symptoms remain one of the biggest challenges in modern-day psychiatry and impose significant burden on patients' functioning and quality of life. They often remain even after successful treatment of positive symptoms. It is my hope and that of the fraternity that we may make progress in this area, with our advancements in genetic and molecular techniques. Shakespeare's authentic descriptions of deficit schizophrenia likely stemmed from his attentive observation of real life. Moving forward, we should aim to let it remain fiction, where it best belongs.

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Patient Centred Psychiatry in Kenya: Lessons from an Elective

In Kenya, where a small psychiatric workforce serves over 55 million people, patient centred care is both essential and challenging. From January to March 2025, I completed an elective at Chiromo Hospital Group, a private psychiatric facility in Nairobi, as part of the University of Nairobi's MMed Psychiatry programme. Unlike public hospitals with limited resources, Chiromo provided rapid access to diagnostic reviews, psychotherapy, and medicines. This contrast showed how resources influence clinical decisions and highlighted practices that still work in lower resource settings.

Listening was key. Slowing down to ask about work, family, routines, and worries built trust that symptom focused interviews rarely achieve and improved follow through. When patients felt heard, they engaged more and we agreed on plans together.

Psychoeducation became a core skill. Explaining diagnoses, outlining options and side effects, and agreeing on a plan helped patients and families make informed choices. Involving families reduced stigma and improved confidence in care. Teamwork mattered too. Psychologists led assessment, therapy planning, and psychoeducation, while medical specialists advised when comorbidity shaped care. This collaboration made integrated care practical.

Teaching reinforced the same habits. Consultant led, case based discussions were anchored to Kenyan practice, weighing cost, access, and family roles. Working through real cases sharpened diagnostic reasoning and comfort with uncertainty.

Context shaped every encounter. Intergenerational trauma, migration, financial strain, and cultural or religious beliefs influenced how people described symptoms, whether they sought help, and how they engaged with treatment. Strong support helped recovery, while isolation hindered it. Care worked best when plans matched the realities people live in.

The elective refined my clinical approach. I learned when to order investigations, when to refer for psychotherapy, and how quickly to start or adjust medicines. When it was safe, I took time to understand the person and the problem before prescribing. When risk was high, I treated promptly and reviewed soon after. The habits that transfer are simple: listen first, decide with patients, ask about the life around the illness, and involve the team early. These rely on intention, not infrastructure, so they adapt across settings.

Looking back, this placement did not replace my training. It rounded it out. It strengthened core skills, deepened my use of psychoeducation and social support, and clarified how to adapt patient centred care across contexts. I left more confident in the basics and more deliberate about making care fit the person in front of me.

Elective Report: Chiromo Hospital Group in Kenya

Introduction
This elective rotation was undertaken as part of the final year of the Master of Medicine (MMED) in Psychiatry program. It was conducted at Chiromo Hospital Group (CHG), a leading private mental health facility in Kenya offering both inpatient and outpatient services. CHG is known for its multidisciplinary approach to mental healthcare and its role as a tertiary referral center.

Objectives of the Elective
• To enhance clinical skills in the diagnosis and management of various psychiatric disorders.
• To gain practical experience in the management of patients in both inpatient and outpatient settings.
• To participate in multidisciplinary mental health care. • To strengthen psychotherapy and psychopharmacological treatment planning.
• To engage in academic and case review discussions as part of professional development.

Activities Undertaken
a. Clinical Exposure • Conducted comprehensive psychiatric assessments, mental state examinations, and risk assessments. • Managed patients presenting with a wide spectrum of psychiatric conditions, including: o Mood disorders (bipolar disorder, major depressive disorder) o Schizophrenia and other psychotic disorders o Anxiety and trauma-related disorders o Substance use disorders o Personality disorders o ADHD and other neurodevelopmental disorders b. Inpatient Care • Participated in daily ward rounds and formulation of individualized management plans. • Monitored medication adherence, side effects, and patient progress. • Assisted in management of psychiatric emergencies and use of rapid tranquilization protocols. • Engaged families in psychoeducation, treatment and discharge planning. c. Outpatient Clinics • Attended adult and adolescent outpatient clinics under supervision. • Participated in follow-up care and long-term management, including medication adjustments and brief supportive therapy. • Coordinated with psychologists, social workers, and occupational therapists for comprehensive care. d. Academic and Research Activities • Participated in bi-weekly academic meetings. • Presented case discussions and engaged in evidence-based treatment planning. • Participated in Grand Rounds which explore emerging trends in psychiatry • Explored current trends in private psychiatric practice in Kenya. • Contributed to discussions on ethical challenges in mental health care.

Skills and Competencies Gained
• Improved diagnostic acumen and confidence in managing both acute and chronic psychiatric conditions.
• Strengthened communication and interviewing skills with patients and families.
• Gained experience in applying the biopsychosocial model in care.
• Understood the dynamics of private mental healthcare delivery and insurance-based systems.
• Developed clinical leadership and teamwork in a multidisciplinary setting.
• Gained clinical insight, case discussion experience, and practical exposure to advanced psychiatric assessment and management under the guidance of experienced consultants.

Challenges Encountered
• Managing high patient expectations in a private setup.
• Balancing pharmacological and non-pharmacological interventions within financial constraints.
• Exposure to treatment-resistant cases requiring complex interventions.

Conclusion and Reflection
The elective rotation at Chiromo Hospital Group provided a rich and diverse learning experience in a real-world psychiatric practice setting. It deepened my clinical competence, broadened my perspective on mental health care delivery in a private facility, and prepared me for independent practice as a future psychiatrist. The opportunity to work closely with experienced psychiatrists and a dynamic multidisciplinary team significantly contributed to my professional growth.

Recommendations
1. Strengthen Partnerships with Private Mental Health Institutions Encourage formalized partnerships or memoranda of understanding (MoUs) between UoN and leading mental health facilities like Chiromo Hospital Group to ensure continuity, structured supervision, and enriched exposure for residents.
2. Incorporate Exposure to Specialized Services Recommend elective placement objectives include exposure to specialized care areas offered at Chiromo, such as:
• Trauma-focused therapy (e.g., EMDR)
• Long-acting injectable clinics (e.g., Invega, Trevicta)
These areas supplement the MMED curriculum with real-world implementation of advanced psychiatric interventions.
3. Advocate for Multidisciplinary Learning Opportunities Suggest integrating structured participation in multidisciplinary team (MDT) meetings during electives, to foster skills in team-based care and coordinated treatment planning.
4. Promote Participation in CPD and Academic Forums Encourage residents to attend Chiromo-hosted CPD events, webinars, and academic discussions that expose them to current trends in psychiatry, mental health innovation, and private sector practice models.

Mental Health Internship at Chiromo Hospital Group

In July 2025, Riyaan Raghavan completed a two-week observational internship at Chiromo Hospital Group's Bustani Branch in Nairobi, under the supervision of Dr. F. Njenga, Dr. Gumbo, Dr. Brenda, and Dr. Wilma. This unique opportunity offered first hand insight into psychiatric diagnostics, treatment planning, and patient care in both inpatient and outpatient settings.

Riyaan observed therapy and medication review sessions, witnessed the management of a first psychotic episode, and learned how psychiatrists use history taking and mental status exams to refine diagnoses. Visits to rehabilitation centers revealed the role of long term recovery programs and occupational therapy, contrasting with medication based interventions.

He also attended academic discussions on ADHD in medical students and the emotional impact of patient loss, actively engaging with clinicians to further his understanding. The experience strengthened clinical observation skills and appreciation for the complexities of mental health care.

Introduction
My decision to apply for this internship came from a deep interest in psychiatry and a desire to help others. While I've previously explored psychological topics through extracurricular projects, this was my first real exposure to a clinical psychiatric setting. Internships like this are rare to find in the U.S., so I saw it as a valuable opportunity to learn. Through this experience, I've become even more confident that I want to pursue psychiatry as a career and continue learning how to support people facing mental health challenges.

Objectives of the Elective
- Observe the daily responsibilities and decision-making processes of psychiatrists (e.g., call notes, morning reports, patient updates)
- Understand how psychiatric care is delivered in both public and private settings
- Observe how diagnoses are made and adjusted over time using tools such as history taking, mental status exams, and corroborative information from family
- Explore various treatment methods including pharmacotherapy and psychotherapy
- The facility also offers electroconvulsive therapy (ECT), though no cases were observed during the internship
- Experience the structure and workflow of psychiatric clinical environments

Activities Undertaken
A. Patient Care
- Observed therapy and medication review sessions with patient consent
- Observed conditions including depression, anxiety, ADHD symptoms, and psychosis
- Witnessed a patient's first psychotic episode and subsequent intervention
- Observed diagnostic re-evaluations (e.g., distinguishing between Bipolar II vs. Major Depressive Disorder)
- Learned how psychiatrists incorporate history from family and symptom progression over time
- Reflected on the emotional difficulty of witnessing serious diagnoses being delivered

B. Outpatient Clinics
- Shadowed approximately four psychiatrists across both Andersen Center and Chiromo
- Noted that outpatient visits (same-day) often involved families and visibly high concern levels
- Compared workflow and communication differences between inpatient and outpatient care
- Visited two rehabilitation centers on the first day focused on long-term addiction recovery
- Learned about how rehab care (e.g., 12-step programs, occupational therapy) differs from medication-based interventions

C. Academic and Research Activities
Attended one clinical discussion on:
- The rising rates of ADHD among medical students
- The emotional impact of patient loss on clinicians
- Gained insight into stressors in medical training and the importance of resilience
- Frequently asked follow-up questions after sessions and received guidance
- Offered diagnostic guesses (often incorrect) to practice clinical reasoning

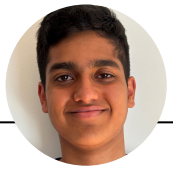
Took notes during academic discussions but not during live patient sessions

Skills and Competencies Gained
- Deepened understanding of psychiatric diagnostic processes and differential reasoning
- Learned about commonly prescribed psychiatric medications and treatment rationale
- Improved observation, clinical listening, and case reflection skills
- Developed empathy and learned to approach mental health cases with nuance Strengthened soft skills: discretion, confidentiality, and respectful communication
- Gained appreciation for the importance of mentorship and leadership in healthcare

Challenges Encountered
- Emotional difficulty watching patients receive life-changing diagnoses
- Some confusion early on distinguishing mood vs. psychotic disorders
- Occasionally struggled to follow complex treatment plans without full clinical background
- Missed one scheduled academic session due to timing conflicts, but later caught up on content (topic: harm reduction models in addiction care)

Conclusion and Reflection
This internship has solidified my passion for pursuing a career in mental health. I now have a clearer understanding of both the complexity and emotional intensity that comes with psychiatric work. The resilience of the patients — and the clarity and compassion shown by the psychiatrists — left a strong impression on me. From topics like harm reduction to global psychiatric care excellence, I've learned how meaningful this field is. I'm walking away from this experience not just more informed, but more motivated to keep learning and eventually contribute meaningfully to mental health care.

Recommendation
To further improve on this internship program, it may be helpful to include short debrief sessions after key patient interactions or clinic days, where interns can ask questions in a more structured setting and hear how different psychiatrists approach different specific problems. Another useful addition could be a brief reading or resource list provided in advance covering basic psychiatric terms, common diagnoses or ethical concerns which would help interns feel more prepared and confident during clinical observations.



The Season She Waited Through

From the Author:

"The Season She Waited Through" is a narrative rooted in truth. While the name Lola Cora is fictionalized to protect her identity, her story is real. I met her during my early residency in psychiatry at Mariveles Mental Wellness and General Hospital, a coastal institution marked by both natural beauty and structural neglect.

Set during the monsoon season, the rain mirrors the emotional weight carried by long-term psychiatric patients — many of whom have been forgotten by time, family, and society. The piece explores themes of aging, abandonment, and quiet resilience within institutional care.

Through Lola Cora's voice, I hope to bring attention to the human stories that often remain unheard in the margins of mental health systems — stories not of pathology, but of endurance and longing.

The Season She Waited Through

They say the Philippines is a country bathed in sunlight, where smiles stretch as far as rice fields, and laughter dances in the warm air. But when the rains come, they come hard. They soak the earth, the walls, and sometimes even the spirit.

It was during one of those gray, unrelenting monsoon seasons that I met Lola Cora.

I had just begun my residency in psychiatry at Mariveles Mental Wellness and General Hospital, an institution perched on the edge of the sea, worn by time and typhoons. On that day, as the heavens wept and the rooftops surrendered to age, I found myself navigating puddles inside the female ward, positioning pails to catch the steady drip of rain. The ceiling groaned, the lights flickered, as I was looking around to check if the patients were dry and comfortable.

That was when I saw her.

Lola Cora, a small, graceful woman with thinning gray hair tucked behind her ears, was going from bed to bed. She was straightening sheets, gently repositioning her fellow patients with the care of someone who had loved deeply and lost much. We call our elderly patients "Lola" if they allow it, the Filipino word for grandmother—a gesture of warmth and belonging in a place that can so easily forget both.

I watched her for a while, quietly moved. After thanking her, I made a mental note to check her chart.

Later, I read that she had long been ready for discharge. Her symptoms were manageable, her behavior consistently calm and cooperative. She had simply overstayed, not because of relapse, but because she had nowhere to go. No one had come. The chart detailed multiple failed attempts to establish contact with her sister. I asked her gently if she remembered any other family. Her eyes searched mine, then drifted downward. She shook her head slowly, not in confusion, but in quiet surrender. The kind of surrender that doesn't scream but sighs. It felt less like she didn't know, and more like she had accepted that no one was coming.

Still, we tried. The social worker and I pored through decades-old records. With help from local authorities, we traced what we believed to be her sister's last known address. However, several months before our search, her sister had lost a drawn-out battle with cancer. The unanswered calls and letters, once so frustrating, suddenly made painful sense.

I braced myself as we broke the news to Lola Cora. She sat in silence. What little hope she had held onto, tucked away silently for years, crumbled in that moment. She didn't cry. She simply nodded, as if she had suspected it all along.

We could have stopped there. Many would have. But something about her, about her grace and her quiet dignity, compelled us to keep looking. She had spent so many years caring for others: fixing beds, comforting fellow patients, holding space for those around her while having no one to hold space for her.

We kept searching. Through baptismal records, handwritten letters, whispers from the past. We combed through forgotten traces of her life, aching for a clue. And finally, we found her. A younger sister, living in Zamboanga, their hometown in the south. When she picked up the phone and we explained, she cried. She had been looking for Lola Cora for years, believing she had vanished for good.

By then, the rains had quieted. The skies, once angry and unforgiving, had cleared.

The monsoon had passed. But Lola still walked around the ward, still fixing beds. Only this time, she looked different. Her hands still moved with the same gentleness, but her eyes—those tired, patient eyes—now gleamed with something I hadn't seen before.

Hope.

When we told her the news, she trembled. Her hands, which had tucked so many blankets and wiped so many brows, covered her face. And then she asked, in the smallest voice, "Uuwi na ako?" Am I going home?

"Yes, Lola," we said. "Your sister is waiting."

The hospital arranged for her to be brought to NAIA. Her sister would meet her there, and together, they would fly back home.

I didn't get to see their reunion. But I like to imagine that as Lola stepped out of the airport, there was sunlight. That somewhere in the clouds, the sun had found its way back through.

And for the first time in years, so had she.

In psychiatry, we often measure recovery in symptoms. But for many like Lola Cora, healing is not just about stability or remission. It is about being remembered after years of silence. It is about finding your place again in a world that once left you behind. It must include belonging. It must include home.

Art and Psychiatry: Closer Than They Appear

I am Different (Autism Spectrum Disorder)

Art and psychiatry are closer than they appear, as the most pure expressions of human being are ideas and feelings. Some months ago, I had the opportunity to write, alongside a trainee partner, a song about autism spectrum disorder as a final project for our child and adolescent psychiatry module. We decided to do so with the purpose of raising awareness about this neurodevelopmental condition, due to the relative lack of public mental health development in our country (Mexico).

The Song's Creation
It was a wonderful experience, with the main objective of stating the core symptoms of this disorder in a supposedly attractive and understandable way. We chose the ukulele as the rhythmic instrument, as we thought it would represent the innocence of childhood and the happiness of youth. The verses were written with a melodically happy succession in mind, and we considered adding a rap interlude to capture attention. Sharing with Our Colleagues

We'd like to share this song with all our colleagues, in the hope that it contributes to a greater understanding and awareness of autism spectrum disorder.

Yo soy diferente (I am different)
Un niño normal (I'm a normal kid)
Neurodivergente (Neurodivergent)
Es mi realidad (That's my reality)

De pocos amigos (I have few, few friends)
Y palabras más (No much more to say)
A veces los ruidos (Sometimes there are noises)
Pueden lastimar (That may hurt me now)

Soy muy selectivo (I'm a bit selective)
Por colores y (For some colors and)
Algunas comidas (Also for some food)
Que me gustan más (That I do like more)

Si yo no te miro (If I do not see you)
O no entiendo bien (Or can't understand)
No enojes conmigo (You don't get mad at me)
Es que así es mi ser (That is how I am)

Mi mundo no es (My world is not)
Como tú crees (How you may think)
El cielo azul (The blue, blue sky)
Lo veo también (I see as well)

Déjame ser (Do let me be)
Yo mismo hoy (Myself today)
Podemos ser (And we could be)
Amigos hoy (Good friends today)

Debes entender, a veces yo me enojo (You must understand, sometimes I'm getting angry)
Pero eso no es por ti, eso es por mi trastorno (But I do not decide, it may be my disorder)
Mis arranques de ira para nada intencionales (A change of emotions that I can't control)
Estas emociones solo son provisionales (These waves of feelings that are getting unfold)

Puedes tú pensar que yo no siento nada (You may think as well that I do not feel anything)
Pero soy como tú, lloro y río, y no es por nada (But I'm the same as you, I laugh, I cry, It is alright)
No es una enfermedad, es una diferencia (It is not a disease, it is a way of living)
Es una condición, debes tomar conciencia (It is my reality, you gotta note the difference)

A veces repito (Sometimes I'm repeating)
Una y otra vez (Once and many times)
Palabras o gestos (Some words or some gestures)
Me hace sentir bien (Makes me feel okay)

No soy diferente (I'm not different)
Un niño normal (I'm a normal kid)
Hoy es un gran día (Today's a sunny day)
Para disfrutar (That we will enjoy)

Mi mundo no es (My world is not)
Como tú crees (How you may think)
El cielo azul (The blue, blue sky)
Lo veo también (I see as well)

Déjame ser (Do let me be)
Yo mismo hoy (Myself today)
Podemos ser (And we could be)
Amigos hoy (Good friends today)

https://youtu.be/wiaOdhSZ1wU?si=TfHLzxz9GwkHl1P5

Thank you for reading!

The editor of this newsletter acknowledges the traditional owners of the land (Narrm) on which this newsletter was edited - The Wurundjeri people of the Kulin Nation.

With respect to Elders past, present and emerging the editor would also like to acknowledge the wisdom and healing that First Nations People internationally have contributed to mental wellbeing and the practice of Psychiatry.

The WPA Early Career Section Committee would like to thank everyone who contributed for making this newsletter possible.

We want to thank the mentors, supervisors, peers and collegues who continue to support Early Career Psychiatrists.

Thank you for reading and please consider submitting to our future newsletters.

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Thank you for contributing!

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