Education & Psychiatry

ISSUE 4, December 2025

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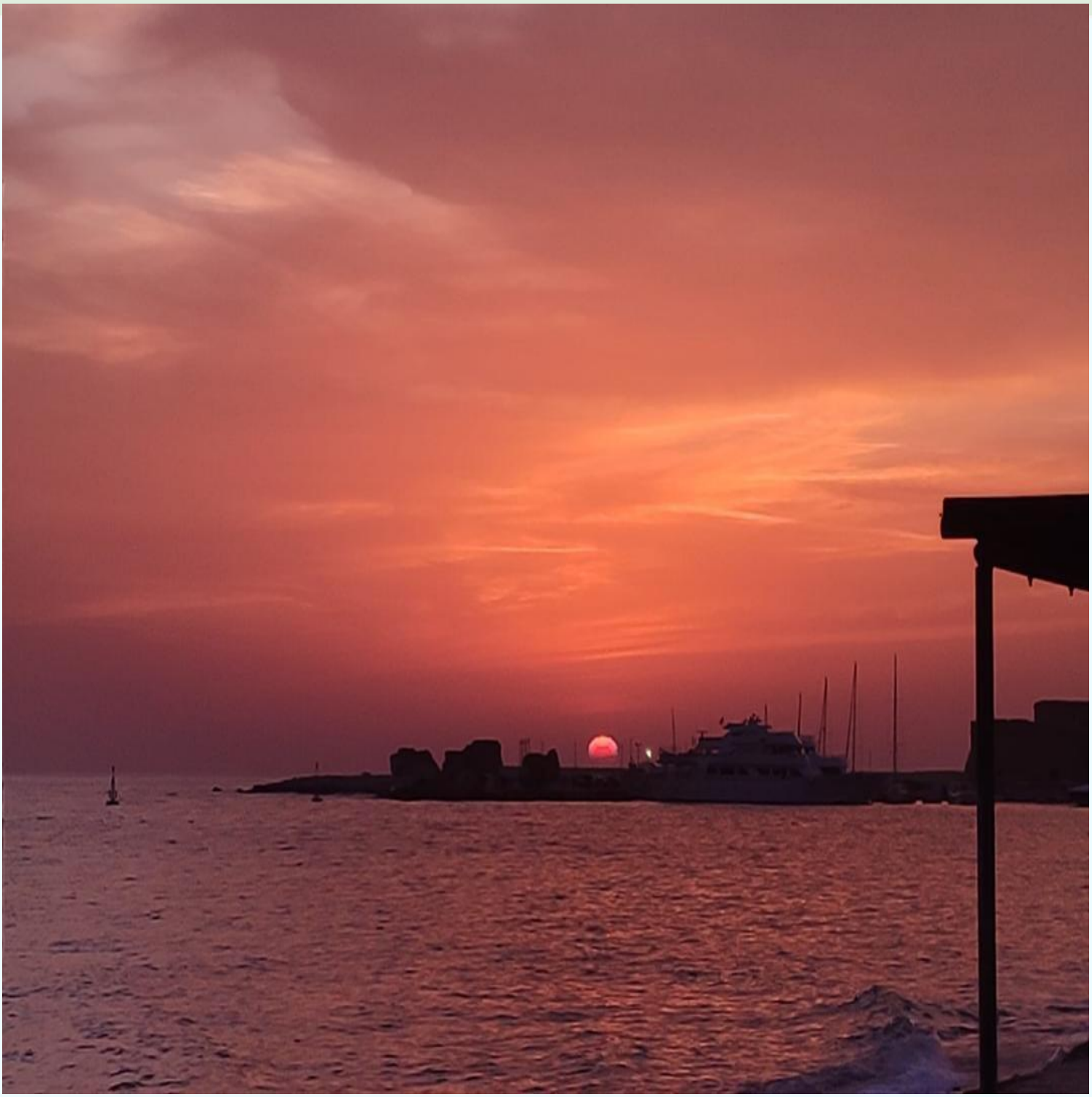

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Editorial

Dear Colleagues,

I am pleased to present this new issue of *Education and Psychiatry* on behalf of the World Psychiatric Association (WPA), Committee on Education and Scientific Publications. We are grateful for the thoughtful engagement and feedback from colleagues across the world.

This issue is anchored by an important contribution from the World Health Organization and the WPA presented at the recent WPA Congress in Prague. The WPA Presidential Panel report details the development and global dissemination of the new World Health Organization Practical Guide for pre-service education. *Educating Medical and Nursing Students to Provide Mental Health, Neurological and Substance Use Care: A Practical Guide for Pre-Service Education* (WHO, 2025) represents an important advancement in embedding competency-based mental, neurological and substance use training.

This issue features the Invited Editorial "Are All Wars the Same?" by Professor Bennett Leventhal, presenting a thoughtful and compelling examination of the universal human consequences of armed conflict. His analysis emphasises that children, families and vulnerable communities consistently bear the most profound and enduring harms — a reality that must remain central to psychiatric education and global mental health policy. This theme is extended in the paper by Dr E. Suardi, which examines the human factors in diplomacy and conflict resolution.

The "Nine Questions" interview series continues with insights from two distinguished leaders in global psychiatry. Prof Norman Sartorius discusses the evolution of leadership development in psychiatry and reflects on the essential skills required for future mental health leaders. Professor Femi Oyebode focuses on the deep connections among psychiatry, culture and the humanities, emphasising the importance of language, empathy and human understanding in clinical practice. This issue further reinforces the value of diverse perspectives (Saipan, United Arab Emirates, Serbia) in psychiatric education.

An overview of artificial intelligence in psychiatric education by Professor Gary Chaimowitz and colleagues considers both the opportunities and the ethical responsibilities associated with digital transformation. The ongoing educational initiatives of early-career psychiatrists are also highlighted, emphasizing their role and responsibility in shaping the future of the profession.
As always, the content in this editorial provides only a brief introduction to the breadth of work included in this issue. Readers are invited to explore the full collection of articles and reports.
Happy reading!

Prof. Norbert Skokauskas MD PhD,
WPA Secretary for Education and Scientific Publications

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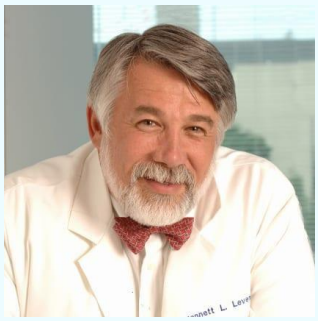
"Are All Wars the Same?



Prof. Bennett L. Leventhal (USA)

WPA Committee on Education and Scientific Publications

Recently, a colleague asked me a curious question: "Are All Wars the Same?" To be honest, I initially did not find this question to be particularly interesting, and a bit sophomoric. So, I chose to pivot to another topic and not answer the question. However, over the course of the next several days, the question kept coming back to me, a bit like a tune "stuck in my head."

Initially it seems obvious that wars are vastly different from many perspectives, but after careful consideration, I am no longer sure that is the case. On the face of it, each new war is different from previous wars. Politicians and military leaders tell us that "*this* war," the one they are leading, is different. They cite differences which, on the surface, seem plausible. "This war" is more justified, more surgical, more necessary than others. Historians may also argue that wars are unique when they are more defensive, offensive, revolutionary, anti-colonial, or "humanitarian." But, in the end, it appears that, as suggested by Prussian General Carl von Clausewitz in his classical book, *On War*, that "war is simply the continuation of politics by other means." To the General, war is the confluence of the "trinity:" 1. primordial violence due to hatred and enmity; 2. chance and probability due to the presence of an army and commanders; and, 3. reasoning proffered by politicians and government policy.

From the perspective of international law and history, it matters enormously who started the war, what their intentions were, and how they fight. Those distinctions are crucial for justice and accountability. One can ably argue that wars do differ based on who "fired first shot," the weapons used, the aggressors' uniform, whether the killing is in support of a "good cause," such as liberation, security, etc., or it is even righting some wrong.

If we stop listening to politicians, generals, or even historians and start listening to the people who bleed, a harsher truth emerges, wars look disturbingly, relentlessly the same. When we strip away the rhetoric, the flags, the medals, and the anthems, there is a recurring pattern: Leaders start wars to gain or protect power, and/or territory, resources, regime survival, prestige, and the illusion of control. Wars don't just "happen." They are deliberate choices by people who calculate that other people's lives are expendable in pursuit of their goals. Across empires and eras, it appears that the people who light the match tend to share the same aims: hegemony, dominance, the destruction or subjugation of others, and securing their own power. This should make us skeptical of any claim that "*this* war" is uniquely about justice or safety.

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When trying to understand the uniqueness of wars, ask children. According to UNICEF, over 473 million children live in war zones. Globally this represents more than one in six children with the proportion of the world's children growing up in conflict zones doubling since 1990. This is not surprising given that we are living in a time with the highest number of conflicts since World War II, before counting "minor skirmishes," like brutal sieges, kidnappings, gang activities, local militia actions, and "security operations," which, when carefully examined, analyses show that civilians often make up 90% of all casualties, with women and children increasingly likely to be among the dead and injured.

These phenomena are not new. They represent what should be a well-known and disturbing pattern, identified over a century ago by Eglantyne Jebb, founder of Save the Children: "Every war is a war against children." She was responding to starving children in post–World War I Europe but, today, we see the same in Sudan, Ukraine, Myanmar, Yemen, Nigeria, Gaza, Afghanistan, and many other places that rarely make the front pages. This century-old conclusion is still a reality. Wars may be launched in the name of sovereignty, security, or freedom, but who ends up in mass graves, in overcrowded displacement camps, in devastated hospitals, and on dangerously overcrowded refugee rafts? The answer is unchanging. The dead and traumatized are children, the poor, people with disabilities, ethnic and religious minorities, and all others who were already on the margins, before the first shot was fired. These are not the people who create battle plans or sign orders.

There is yet another sense in which wars are the same: they all attack the future. War does not just spill blood during the conflict; it also causes great harm to the future. This comes in two forms. The first is the loss of the youth who are sent to battle as soldiers or who are the frequent victims of the war. Their deaths and maiming destroy entire generations. The second consequence is loss or damage to the environment. War disrupts ecosystems, depletes natural resources, pollutes the environment, and jeopardizes the health for generations. From oil-well fires and scorched-earth tactics, the toxic residues left by munitions and their manufacture, burned cities, destroyed crops and animals, and contaminated water, war leaves behind landscapes that can no longer easily and safely sustain life, let alone healing and repair. In places used for extensive weapons testing and military exercises, investigations have documented radioactive and chemical contamination capable of turning entire regions into health and ecological nightmares. Add to that the landmines buried in fields, the unexploded bombs under playgrounds, the burned forests, and the poisoned rivers and lakes. These do not go away when politicians sign a peace treaty. In these settings, children grow up breathing dust from abandoned uranium mines or destroyed toxin laden factories and other buildings or drinking water filtered through chemical filled rubble. In short, when wars officially end, the environment is scarred often as much as the people who live in it.

Even at this point, some may find that there are wars which are special, unique, or worthwhile. For example, some argue that a war is different if "*this* war" is necessary to stop genocide or aggression. Even when a war feels tragically unavoidable, the idea that it will be different or that there will be true winners is fantasy. Even

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Neville Chamberlain, not exactly a pacifist, captured this concept with brutal clarity: “In war, whichever side may call itself the victor, there are no winners, but all are losers.”

Political leaders, journalists, and even some historians will keep insisting that “*this* war” is different. Perhaps it feels that way from the briefing room in the presidential palace, in the historian’s study, or the general’s bunker. But, in the cellar where a child shudders and covers their ears as rockets and artillery shells explode nearby, in the hospital that has run out of supplies, and in the field that can no longer safely be plowed because it is seeded with mines, wars lose their alleged uniqueness.

So, “Are all wars the same?” I have come to realize that my initial reaction was wrong. It is an important question for which there are two honest answers:

Wars are not the same for the people who are determined or inspired to start them.

Wars are tragically, horrifyingly the same for the people who cannot escape them.

This leads to the difficult question: Which role will you play? A starter, a stopper or a victim? Being a passive observer is not an option.

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WPA–WHO Presidential Panel: Advancing Pre-Service Education for Mental, Neurological and Substance Use Care

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At the 2025 World Congress of Psychiatry in Prague, the World Psychiatric Association (WPA) and the World Health Organization (WHO) jointly advanced a key global education agenda: strengthening *pre-service education* for doctors and nurses to provide effective, compassionate, and evidence-based care for people with mental, neurological, and substance (MNS) use conditions.

The Presidential Panel, chaired by Mark van Ommeren (Head of Mental Health and Substance Use Unit, WHO) and Danuta Wasserman (WPA President), brought together psychiatrists, psychologists and other mental health professionals from different regions to introduce and discuss the new WHO publication *Educating Medical and Nursing Students to Provide Mental Health, Neurological and Substance Use Care: A Practical Guide for Pre-Service Education* (WHO, 2025). The session reflected the growing recognition that the foundations of mental health care must be laid early.

The new WHO guide represents a major step forward in embedding MNS care within medical and nursing curricula. It promotes competency-based education, ensuring that all future doctors and nurses acquire the skills, knowledge, and attitudes required to support people with MNS conditions throughout the life course. The guide provides educators and policy-makers with a structured approach to curriculum integration, highlighting the importance of whole-of-curriculum design, experiential learning, and intersectoral collaboration between the health and education sectors. It encourages academic institutions to adapt teaching materials to local realities while maintaining the scientific rigour and ethical standards central to WHO's guidance on mental health, including the mhGAP framework. At the core of this guide are 12 core competences identified as essential to future medical and nursing students' ability to provide quality MNS care. Each is defined according to the

knowledge, skills and attitudes that lead to competence and accompanied by guidance on approaches and tools for developing learning content and assessing progress in their development.

The 2025 guide builds upon and extends the foundations established in the earlier WHO publication *Enhancing Mental Health Pre-Service Training with the mhGAP Intervention Guide: Experiences and Lessons Learned* (WHO, 2020). That earlier document was the first to consolidate international experiences and lessons learned in applying the mhGAP Intervention Guide (mhGAP-IG) within university and college settings, drawing also on the outcomes of three WHO consultations held in Prague, Mexico City (WPA World Congress), and Geneva in 2018, where global experts identified key opportunities and barriers to integrating mhGAP-IG content into pre-service education.

To create this new guide, WHO began by scoping the academic and grey literature on university education in mental health care among doctors and nurses. In total, the review covered 24 academic publications, 22 university curricula collected from education institutions across all 6 WHO regions, multiple WHO resources and other key stakeholder guidance documents and various international standards and national professional guidelines. As part of this initial phase, WHO conducted key informant interviews with 43 stakeholders across the world, including deans and professors of medical and nursing schools, representatives from ministries of health and education, accreditation and licensing boards, professional societies, students and people with lived experience of MNS conditions. The scoping period culminated in an in-person 2-day workshop held in Geneva in December of 2022 to share experiences, define key competencies in MNS education and outline approaches to developing the guidance. Thereafter, content of the guide was iteratively developed, informed by consultations and reviews from a wide range of stakeholders, including key professional associations such as the World Psychiatric Association (WPA), the International Council of Nurses (ICN), the World Federation of Medical Education (WFME), the International Association of Medical Regulatory Authorities (IAMRA), the International Federation of Medical Student Associations (IFMSA), among many others, leaders in academic institutions, ministries of health and education, and other UN and Civil Society partners. A final in-person expert consultation workshop was held in Shanghai China, bringing together many of the same stakeholders to review the guide's content and make recommendations for finalization. In April of 2025, the document was published and has since been disseminated through a series of online and in person events, including in-person dissemination activities at the ICN, WFME, IFMSA annual congresses and conventions and through the WPA Presidential Panel described herein.

This progressive work and multiorganizational endorsement of this document reflects a shift from short-term, in-service workshops towards a more sustainable model of workforce development, where every medical and nursing graduate enters the profession already equipped with the essential competencies for mental health care. This approach is cost-effective, scalable, and equitable—helping countries to close the mental health treatment gap and advance progress toward the Sustainable Development Goals and Universal Health Coverage.

During the 2025 session in Prague, panelists and discussants—including experts from Switzerland, Sweden, Tunisia, Ukraine, Mozambique, and Norway—shared regional perspectives and experiences with adapting the

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mhGAP framework for pre-service use. Presentations covered curriculum design in low- and middle-income countries, integration within national programs, and alignment with accreditation systems and quality standards in higher education. Speakers also reflected on persistent barriers, such as time constraints in already crowded curricula, shortage of trained educators, limited clinical placements in community settings, and institutional resistance to change.

Despite these challenges, participants agreed that opportunities for innovation and collaboration are expanding. Examples shared during the session demonstrated how mhGAP-based teaching can enrich existing courses through case-based learning, simulation exercises, and digital platforms, without requiring major additional resources. Several speakers emphasized the value of international partnerships, joint faculty development initiatives, and students' and clinicians' engagement as drivers of successful curriculum transformation.

The discussion concluded with a collective call to action: to advocate for policy alignment, mobilize resources, and field-test the new WHO guide in diverse settings, with close monitoring and evaluation. Both WPA and WHO reaffirmed their commitment to working together to expand pre-service education for MNS care, bridging academic education with service delivery and global mental health policy. This collaboration between WHO and WPA on pre-service education—spanning the early informal consultations in 2018, a 2020 mhGAP- based pre-service framework, and the 2025 *Practical Guide*—represents a sustained international effort to prepare the next generation of health professionals to meet the mental health needs of populations worldwide. By embedding mental health within all stages of professional education, this partnership helps ensure that the global workforce is equipped to deliver equitable, person-centred, and high-quality care for all.

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Interview Features

"Professor Sartorius: Nine Questions, Part II"

Earlier this year, Professor Norman Sartorius celebrated his 90th birthday—a milestone that prompted wide recognition of his extraordinary contributions to global psychiatry. Our first interview with Professor Sartorius, attracted considerable attention from colleagues around the world. In light of this response, and inspired by the book Professor Sartorius together with Prof. G. Thornicroft published this year "Practical Professional and Leadership Skills, A guide for Health and Social Care Professionals", we invited him to continue the conversation. In this second part, we present nine additional questions, exploring themes raised in his new book and offering further reflections from one of the most influential figures in contemporary psychiatry.

1. **Professor Sartorius, how did the idea for the leadership and professional skills courses first emerge? Could you share the story behind their inception?**

When I first came to England on a scholarship I was astonished to see that most of the young psychiatrists there were no better than those in my own country when asked to make a presentation, or approach a colleague to ask for help at work. As years went by while working for the World Health Organization visiting in many countries I saw that the situation was not different in other countries. Nobody seemed to be keen to include training in the use of social and leadership skills in the routine training of health workers in general nor in that of psychiatrists - who need those skills more than other professionals. I became keen to see whether it would be possible to create a brief training course for psychiatrists in training and those early in their career. An opportunity for this emerged at the end of my time at the World Health Organization in 1993. While working there I was occasionally given an honorarium for lectures which I, being a staff member of WHO, could not accept and which was therefore saved in a special account. Before retirement I proposed to grant that money to the National Institute of Mental Health and Neurosciences in Bengalore, India with the explicit guidance that the funds should be spent for training young psychiatrists in the use of professional and leadership skills.This was approved and we held a course in Velore, India. The course was in many ways a revelation. The course was intense, lasted three days, ten hours a day. It showed that in that period it was possible to enable participants to learn and use a number of social and communicational skills. The course also had an effect on signs of burn-out which were present at the beginning of the course and which vanished by its end. The relationship between the participants and with the teachers remained cordial and advice about changes of behaviour was willingly accepted.

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I was both surprised and delighted by this experience and organized other courses in different countries. On each occasion the participants enjoyed the effort, learned to use what we taught them and became close to each other, possibly because the courses were strenuous and required considerable joint effort. The most striking example of how much the courses contributed to the relationship among the students was the course in Berlin, some twenty years ago (Liu, S et al 2025). The participants were psychiatrists from countries which have just ended a war during which they became independent countries previously encompassed by Yugoslavia and the course was proposed by Professor Helmchen, with the support of the Brandenburg Academy of Sciences in order to overcome the memories of the recent wars and develop collaboration between professionals in those countries.

The course was a success. Not only did the psychiatrists from those countries – Croatia, Bosnia, Montenegro and Serbia work well together during the course; on return home they carried out a collaborative study which was presented at the World Congress of Psychiatry a few years later and which received the prize as the best study carried out by young psychiatrists. Both experiences – the willingness to change behaviour and accept suggestions about changes without rancour and the readiness to put aside political stances and work with colleagues – were very encouraging and added to my determination to continue with courses.

2. **Over the years, these courses have reached psychiatrists in many regions of the world. Could you share a few figures—approximately how many courses have been held in how many countries, and how many early-career psychiatrists have participated?**

In all we must have held some 120 courses in some 50 countries. I am giving approximate numbers because some of the courses were independent, some linked to congresses, some held virtually, some with a pause between the days of the course. I never counted all the participants but believe that that we have included some 2000 early career psychiatrists over the past thirty years- I say we because I was working with other teachers in a large majority of courses. My co-teachers have been an essential ingredient of the courses. Among them were David Goldberg, Janos Furedi, Ee Hok Kua, Dinesh Bhugra, Heinrich Heinze, Cyril Hoeschl, Jan Libiger, Dmitry Krupchenko as well as least one of he teachers from the places in which the courses were held. Graham Thornicroft taught with me over the past several years and one of the results of our collaboration is also the book on Practical Professional and Leadership Skills which has just been published (Sartorius, N. and Thornicroft G. 2025). The courses are very intensive and having a partner teacher is an important ingredient, not only because of their contributions but also because students can witness differences in the manner of teaching about skills and their application.

3. **In your view, why is there such a great need for these courses?**

I believe that these courses and the education about the leadership and professional skills is an essential part of the education of psychiatrists – not only because the quality of their contribution to clinical practice depends on having the skills which we are teaching but also because psychiatrists must act outside their clinical settings if they wish to promote mental health, in contact with public health authorities, the general public, teachers, the judiciary and many others.

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It is sad that the education about these matters is not uniformly seen as the essential part of training, a part which cannot be replaced by any other and which will make psychiatrists fulfill the duties which their profession includes.

4. **How have the courses evolved over time? What new elements or perspectives have you incorporated in recent years—and which core principles have remained timeless or "evergreen"?**

The courses have changed very little over the years. They are focused on elementary and essential skills and these have remained at the core of good practice and of public health activities of psychiatrists so that we do not feel that we had to change the contents of the courses. The original format stood the test of time and reports from the participants have repeatedly stressed the usefulness of the interactive and participatory style of the courses.

5. **After decades of leading these courses, what inspired you to bring this experience together in your new book Practical Professional and Leadership Skills?**

Graham Thornicroft and I are both convinced that the education in the skills which are taught in our courses must become a part of education of all psychiatrists worldwide. It would be wonderful if we were able to be everywhere and have all the time in the world to help our younger colleagues to acquire the skills which we teach. This is not possible and we believed that other teachers who understand the essential importance of the skills which we teach will find it helpful to have the description of the way in which skills have been taught in our courses available. Meanwhile, from preliminary contacts and reactions we realized that it is not only the teachers who are interested in having the book to hand when they teach skills but also that psychiatrists and others – such as social workers, community nurses, and other staff responsible for mental health care find the book useful as a learning tool which they can use to improve their skills and to teach others about them.

6. **From your perspective, what are the three most essential leadership qualities that the next generation of psychiatrists will need to meet future challenges in mental health?**

Which leadership qualities will be most useful and important will depend on the setting and the personality of the leader. Nevertheless, in our opinion psychiatrists and other mental health workers should be competent in their profession, empathic in their relationships with people whom they treat and with their families, willing to continue learning about human relationships and mental health and aware of areas of competence which they improve

7. **You have often spoken about values and awareness in professional life. How would you define "conscious leadership" in today's complex and often tumultuous world of medical leadership?**

For psychiatrists - and others working in the field of mental health - it is probably more important than for others in the field of medicine to compare their personal value system with the ideals of care for people with mental illness and their carers. If there is no harmony between them psychiatrists will not perform well and will

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be poor teachers of others involved in the system of care. Since value systems, once established, change slowly a disharmony between the two value systems is probably an indication that the psychiatrists should seek another profession.

8. **What personal message would you like to share with the psychiatrists who have participated in your courses—and would you recommend they complete their education by buying the book?**

Participants in the professional skills and leadership courses remain forever members of a worldwide community of people who recognized the need to improve the skills which they need in their work and who did something about it. The courses are intensive and require considerable effort from teachers and students: I believe that getting through the effort successfully makes the students and the teachers closer to each other, makes them align their values and retain memories of a time together, I hope that the book which Professor Thornicroft and I produced will be reminding them of the courses which they attended and help them to instruct other colleagues in their setting. One of the stated goals of the courses is that the participants should share what they have learned with others and the book might make that easier.
Those who did not attend a course might use the book to teach themselves or others about skills: we have tried to provide practical and simple advice to readers so that they can acquire some of the skills themselves and teach about them

9. **Looking ahead, what gives you the greatest optimism about the future generation of psychiatric leaders around the world?**

I watch the coming world with guarded optimism. The traditional systems of mutual help and family links have been changing over the past few decades diminishing opportunities to learn skills of communication, to enjoy togetherness, to seek an exchange views and to wish to build things together. The emphasis on relying on oneself and one's communication apparatus without too many personal contacts with others in the same country, with others in the same living space and in one's profession is gaining grounds. The numbers of robots who are offered instead of friends is increasing. I believe that this is not good for the future of humanity and that we should make it easier for people to like each other and build their present and their future together. It is possible that our courses will make a contribution to these goals.

The interview with Professor Sartorius was prepared by the WPA Committee on Education and Scientific Publications.

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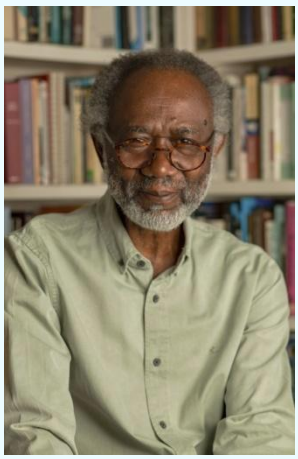
Interview Feature

Beyond Symptoms: Professor Femi Oyebode on Culture, Creativity, and the Future of Psychiatry



Professor Femi Oyebode stands as one of the most distinctive voices in contemporary psychiatry — a clinician, scholar, poet, and leading authority on descriptive psychopathology. Born in Lagos, Nigeria and shaped by an early passion for literature alongside rigorous scientific training, he has spent his career demonstrating how psychiatry is enriched through the humanities. From his stewardship of *Sim's Symptoms in the Mind* — now the discipline's definitive text on psychopathology — to his influential writings on culture, delusional misidentification, theatre, and the medical humanities, Professor Oyebode has helped expand the intellectual and artistic horizons of modern psychiatric practice. In this interview, he reflects on his international journey, the power of culture and language, the role of the humanities in medical education, and the future of psychiatry in an increasingly complex world.

1. **You were born in Lagos, Nigeria and nurtured an early love for literature and poetry, while also being guided toward a career in medicine. Looking back, how did these formative influences — both the humanities and the sciences — shape the psychiatrist, teacher, and writer you became?**

I became aware, from a very young age of my interest in literature, and if I might put it this way, of my gift for writing, especially poetry. In my generation, there was a great emphasis, perhaps even overemphasis, on the sciences. This attitude was prevalent in all postcolonial countries and societies, as the sciences were seen as necessary for nation building. My own father had studied maths and physics and later trained as a meteorologist. I was good enough in the sciences including biology and it was natural that I was directed towards medicine. Initially, I kept both aspects of my life very separate but decided in the early 2000s to try to integrate my interest in the humanities with my professional life as a psychiatrist. This resulted in publications such as Mindreadings: literature and psychiatry and Madness at the Theatre.

2. **When you moved from Nigeria to the UK in the late 1970s, you embarked on the journey of an international medical graduate. What challenges did you encounter, and how did these experiences shape your path to becoming one of the eminent figures in psychiatry?**

I graduated in 1977 from the University of Ibadan Nigeria and completed my house jobs at the University College Hospital, Ibadan. I worked for a year at the National Neuropsychiatric Hospital Aro, Abeokuta from July 1978-June 1979. I had developed an interest in psychiatry whilst in medical school and had decided on a

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career in psychiatry quite early as a student. I was inspired by Professor Tolani Asuni, a highly respected Nigerian psychiatrist, who oversaw our 4th year psychiatric posting. In those days, our posting was a 2-week residential placement at the National Neuropsychiatric Hospital. This meant that we were totally immersed in the life of the hospital and participated in much more than merely attending classes and observing what went on in the clinics and wards. It was a wonderful experience for a student who was already interested in psychiatry. Whilst working as a qualified doctor, at the National Neuropsychiatric Hospital Aro, I was taught and supervised by Frieda Schoenberg, a German psychiatrist who had settled in Nigeria. Her clinical psychiatry and approach to psychopathology were exemplary. So, you could say that I was already well prepared for training and working in the UK when I arrived in 1979. The transition was far from smooth but once I was appointed to the Newcastle Training Scheme in 1980, everything fell into place. I remained in Newcastle for 7 years, completing my basic and higher professional training.

3. **You took over Sim's Symptoms in the Mind in 2005, and it has since remained the leading textbook in descriptive psychopathology. What inspired you to devote yourself to this field, and how do you see the role of psychopathology in psychiatry today?**

Andrew Sims' first edition was published in 1988. Andrew published the first 3 editions and I took over the 4th edition and have to date edited 4 editions. The book will have its 40th anniversary in 2028 and I am in the process of preparing the 8th edition to coincide with the 40th anniversary. Alongside my interest in the medical humanities, I have an abiding interest in philosophy, which I suppose demonstrates my preoccupation with conceptual issues. I had previously studied for a doctorate in the philosophy of mind prior to taking over Sims' Symptoms in the Mind. So, taking over his already well-established text on psychopathology seemed like a natural extension of my interests. It was a daunting task, no doubt, I hope that readers continue to find it a useful text, a good introduction to psychopathology. There is no doubt that psychopathology is the foundational discipline of psychiatry. It lays the groundwork for nosology. I think of nosology as a work in progress whereas psychopathology provides the infrastructure for making sense of the clinical encounter and for prompting an understanding of what the basic underlying categories of illnesses and disorders might look like.

4. **You have contributed greatly to the study of delusional misidentification syndromes. How do you see culture shaping psychopathology, and to what extent can we speak of psychopathology as being universal?**

My starting point is that psychiatric disorders are manifest in a life and are therefore subject to all the features of human life, including culture and language, social factors, and the multiplicity of historical factors that determine, influence and shape our behaviours and understandings of the world. If you take a neurological condition such as Parkinson disease, the manifestations are mostly determined by neurology. Of course, folk understandings influence the responses to the condition and the likelihood of compliance with treatment. But, in the main the symptoms and signs are driven by neurology. On the other hand, if you take anxiety disorder as an exemplar, the presentations are influenced by context. There is little reason to think that the physiological symptoms are different in human beings but in some contexts, the cardiac symptoms such as palpitations

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predominant whereas in others it is the dizziness and syncope that figure largely. Indeed, if you look at European presentations in the 19th & early 20th century, women largely swooned and passed out. A presentation that is rarely seen in todays' world. So, yes culture matters.

5. **In your writings, you have addressed poverty and social inequality as central influences on mental health. Could you share how you see these forces shaping both the experience of mental illness and the role of psychiatry in responding to such challenges?**

The roles of poverty and social inequality are pervasive and ubiquitous. At every stage of life these factors influence physical and psychological development. Maternal care shapes the health of the foetus. Maternal nutrition, antenatal care, and care at birth influence the health of the baby. Poor care at birth is associated with likely birth injuries and these have consequences for the development of the child. Living conditions in infancy and childhood have extraordinary consequences for the child. Living in overcrowded and densely populated and highly polluted environments have effects on growth and in the long-term on the likelihood of reduced life expectancy, and for the development of dementias for example. My own view is that public health is as important in psychiatry as it is in other specialities.

6. **Alongside your psychiatric career, you have published volumes of poetry and works such as Mindreadings: Literature and Psychiatry and Madness at the Theatre. How do you see psychiatry and literature enriching one another?**

For me, psychiatry and the humanities and the arts are inseparable. My most recent book Doppelgänger is an exploration of autoscopy through the lens of Classical Greek theatre, Roman theatre, fiction, cinema, and neuroscience. I am currently working on a book on anomalous perceptions and I have drawn examples from Cervantes' Don Quixote which is itself drawn from North African Moorish traditions, and I have also taken my other examples from the Arabian Nights, Patrick McGrath's novel Spider, and so on. I will be soon speaking at a meeting where I will talk about Poets on Psychiatrists. So, you can see that my project is to further integrate the humanities and psychiatry as far as is possible.

7. **You have also been a strong advocate for the inclusion of the humanities in postgraduate medical education. Why do you believe this is essential for the training of psychiatrists?**

The humanities have a role in teaching us about the life of patients, so that we come to properly appreciate that a disease is manifest in a life. This will lead to better medical care as the person of the patient will not easily be lost in our approach to patient care. The humanities also offer an insight into how clinical care, the clinical encounter impacts on patients' lives. So, the reading of memoirs of illness, or indeed any literary text can shine a light on the ways in which our behaviour affects patients. Finally, psychiatry is one of the most language dependent medical specialities. Literature, and the humanities allow us to focus on the use of language and teaches us to prioritise language, to listen attentively, and to recognise the power of language in the clinical encounter.

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8. **In many educational systems, even at the pre-medical stage such as IGCSE or A-levels, students are required to focus exclusively on three sciences in order to progress into medicine. Do you think this narrow requirement risks excluding or discouraging students with broader intellectual and creative talents, and how can psychiatry as a discipline continue to benefit from such minds**?

The British system of education forcibly narrows the choices that children have far too early. But not all systems operate that way. The French Baccalaureate allows for a more extensive and deeper knowledge of the sciences and the arts for much longer. The American liberal arts degree which like the French system also allows for a wider understanding of human knowledge. In an ideal world we ought to be aiming for education rather than training. The current British system which my own country of birth, Nigeria, like a lot of other postcolonial countries adopted, ought to be re-evaluated for its emphasis on training people for a job rather than educating people so that they can be independent thinkers.

9. **During your time as Chief Examining Officer at the Royal College of Psychiatrists, you oversaw a shift from the traditional long-case and short-case examinations to structured, checklist-based assessments. What are your reflections on this transition, and do you feel that the art and depth of psychiatry are still being adequately captured in the newer systems?**

I agree that in moving away from the traditional long case, essays, and short answer question papers we lost something in our assessment toolkit. The benefit was that our examinations became more reliable, less open to the vagaries of the opinion of an individual examiner, the so-called rogue examiner. But the degree to which we lost face validity is yet to be fully established. As you say, the assessment system, in conjunction with the tick box approach that the DSM favours have had a regrettable influence on clinical practice. This is well understood by most people and the question is how to proceed given what we know. We cannot return to the traditional long case; we no longer have the resources to run those kind of examinations. Hospitals are too busy; the patients do not stay for long in hospital and are far too unwell to participate in examinations. So novel solutions will have to be found.

10. **You have received the Royal College of Psychiatrists' Lifetime Achievement Award in recognition of your outstanding contributions to the field. Have you had any connection with international associations such as the World Psychiatric Association (WPA), and how do you see their role in advancing psychiatry globally in the future?**

I certainly believe in the important role and work of the WPA and EPA (European Psychiatric Association). I have not had extensive involvement in either body but of course, often attend and speak at their conferences. There is a need for international organisations that help to improve standards of practice and training. Then there is a need for affiliation, for confraternity, we are social animals after all.

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11. Out of your many works — from poetry to textbooks — which one is most personally meaningful to you, and why?

That's a very difficult question to answer. Chinua Achebe the Nigerian writer in response to that question, said 'that is like asking me which of my children I prefer'. Writing for me is an ongoing process, and I hope that my best work is still ahead of me.

12. As someone who is widely read in both psychiatry and the humanities, is there a particular book, inside or outside psychiatry, that has most profoundly influenced your thinking?

I think about writers rather than a single book. Chekhov trained as a doctor, and he continued to practise throughout his life and of course was both a dramatist and short story writer. I recommend his short stories. His stories include many that involve doctors, medicine, and for psychiatrists his novellas Ward No. 6 and The Black Monk are worth reading. I read and re-read Jorge Luis Borges, for his imagination and wit, his extraordinary learning and his attunement to language.

13. Finally, what message would you like to share with the next generation of psychiatrists worldwide about the importance of culture, humanity, and creativity in shaping the future of psychiatry?

I always think that psychiatry, as a discipline, requires that you bring the whole of yourself to the clinical encounter. This means that all the human attributes that we have, our facility with language, our understanding of culture and the humanities, our appreciation of the arts of our society, and our empathy and grace should always accompany the technical knowledge and skills that we have acquired as doctors. Then immerse all that in humility and profound gratitude that we have the privilege to help other people.

The interview with Professor Femi Oyebode was prepared by Dina El Gabry and the WPA Committee on Education and Scientific Publications.

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The Emirati Board of Psychiatry: The Establishment of the UAE's National Qualification in Psychiatric Training

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Psychiatric training in the United Arab Emirates has advanced into a new era with the establishment of the Emirati Board of Psychiatry in 2023 under the National Institute of Health Specialties (NIHS). For many years, candidates relied on external qualifications such as the Jordanian Board, the Arab Board, or international certifications obtained abroad, including American Boards and Canadian clinical fellowships, to secure specialist or consultant status.

Today, the UAE proudly offers its own national Tier 1 psychiatric qualification, aligning the country's training pathway with internationally recognized standards.

Internationally Accredited Training Programs in the UAE

A central strength of the psychiatric training landscape in the UAE is that all residency programs are internationally accredited, providing trainees with a world-class educational foundation. These include:

- Accreditation Council for Graduate Medical Education – International (ACGME-I) accreditation, ensuring alignment with U.S.-based competency frameworks and training quality
- Canadian Royal College of Physicians and Surgeons–aligned standards, integrated into curriculum development, assessment principles, and competency evaluation

Together, these accreditations ensure that residents enter the Board examination process with an exceptionally strong and globally recognized training background.

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Governance and Structure: Strong Foundations for Academic and Assessment Excellence

The Emirati Board operates through two complementary committees:

- The Scientific Committee, which oversees curriculum development, academic standards, competency alignment, and scholarly expectations
- The Examination Committee, responsible for examination design, delivery, monitoring, and quality assurance

The Examination Committee also incorporates AI-supported benchmarking and exam development tools, ensuring modern, data-driven assessment practices consistent with international innovations in medical education.

This governance structure ensures rigorous quality, consistency, and integrity across all stages of assessment.

High Entry Standards: Ensuring Scholarly and Clinical Readiness

To uphold excellence, candidates must meet strict prerequisites before entering the third part, including:

- 48 months of accredited psychiatric residency training in the UAE under internationally recognized accreditation systems
- Compliance with the requirements of the National Institute for Health Specialization, Emirati Board.
- At least one peer-reviewed publication, demonstrating scholarly engagement, academic contribution, and commitment to research-informed practice

These entry standards foster a culture of professionalism, critical thinking, and scholarly growth among future psychiatrists.

Three-Part Examination Pathway

The Emirati Board certifies candidates through a structured and comprehensive three-part examination:

1. First Part Examination – MCQ (Basic Sciences)
2. Second Part Examination – MCQ (Advanced Clinical Knowledge)
3. Third Part: Comprehensive Clinical Examination (CCE) – a rigorous, practical evaluation using:
    - Standardized clinical case scenarios
    - Simulated patients (SPs)
    - Structured scoring rubrics
    - Vetting and standardized-setting procedures
    - Multi-level review processes guided by medical education specialists

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- Continuous alignment with up-to-date international assessment standards

The CCE evaluates critical domains, including history taking, mental state examination, risk assessment, communication skills, clinical reasoning, formulation, and management planning.

Commitment to Fairness, Inclusivity, and Diversity

Fairness, inclusivity, and diversity are not only values but core operating principles of the Emirati Board of Psychiatry. To ensure equitable assessment:

- Examiners are selected from diverse professional and cultural backgrounds
- Most examiners are Western-trained or internationally qualified, bringing global perspectives to evaluation
- Standardized setting, blueprinting, structured rubrics, and evidence-based scoring reduce bias
- Continuous quality checks, monitoring, and external review ensure transparency, reliability, and academic integrity

These measures guarantee that every candidate is assessed fairly, consistently, and to the highest international standards.

A National Tier 1 Qualification Shaping the Future Workforce

The Emirati Board of Psychiatry is officially recognized as a Tier 1 qualification within the UAE. Successfully completing all examinations enables psychiatrists to progress to consultant status within two years, underscoring the Board's rigor and its vital contribution to building a strong and competent national psychiatric workforce.

A Historic Milestone for Psychiatric Education in the UAE

The establishment of the Emirati Board of Psychiatry represents a landmark achievement in the UAE's medical education landscape. With its rigorous governance, internationally aligned training standards, innovative examination methods, and principled commitment to fairness and inclusivity, the UAE has positioned itself at the forefront of psychiatric training in the region. The Board stands as a testament to the nation's dedication to excellence, capacity building, and the continuous advancement of mental health services.

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Psychiatry in Saipan, a Tropical Pacific US Territory

Michael Chen

Commonwealth Healthcare Corporation, Saipan, USA

Saipan is 135 miles (217 km) north of Guam, 3,700 miles (5954 km) west of Hawaii, and 1,500 miles (2414 km) southeast of Japan. Spain, Germany, and Japan previously colonized the indigenous Chamorro and Carolinian peoples of this tropical archipelago.

The relationship with the United States was formalized with the Commonwealth of the Northern Mariana Islands (CNMI). Islanders gained US citizenship in 1986, but they have only non-voting membership in the US House of Representatives; to this day, they are not permitted to vote in the Federal elections for the US presidency. The islands are tropical, rural, and surrounded by saltwater, which fills some of the deepest trenches on Earth. The island of Saipan is 12 miles (19 km) long and, according to the 2020 US Census, had 43,385 people; Tinian had 2,044, and Rota had 1,893, totaling 47,329 across the 14 islands of the archipelago.

In the 2020 US Census, 43.7% of respondents in the CNMI reported their race as Native Hawaiian and Other Pacific Islander alone. 22,054 (46.6%) identified as Asian, with 15,456 (32%) identifying as Filipino, with no additional details. The language many parents speak may differ from that of their children. Tourism from China, Korea, and Japan has been the majority of the modern economy. Before 2007, the CNMI minimum wage was set at $3.05 per hour by Public Law 9-73, while the US minimum wage was $4.75 per hour. The CNMI minimum wage was gradually made to match. This contributed to the collapse of the garment industry. Other businesses have also made varied contributions, including casinos and recreational marijuana. Some Chamorro families recall seeing a short-haired Caucasian woman, alleged to have been Amelia Earhart, while imprisoned in Saipan. Japanese propaganda that the United States military would be brutal and merciless led to masses of Japanese civilians jumping from Suicide Cliff. Those that survived the US takeover, Chamorro, Carolinian,

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Japanese, Okinawan, and Korean, were kept in internment camps. After Tinian, an island nearby, was taken by the US, it was secretly used to store the atomic bombs before their use. The end of WWII would be declared, but it would be 305 more days before the civilians would be released from Camp Susupe on July 4, 1946.

Spanish colonization and the introduction of Catholicism eradicated many ancient customs, including those related to medicine. Nonetheless, modern cultural healing practitioners, *suruhåna,* are present and use medicinal plants, lotions, massage, and dietary advice to heal. Today, many families will consult the *suruhåna* before seeking care from doctors at the hospital using Western medicine.

Saipan's public schools include 9 elementary, 7 middle, and 4 high schools. Northern Marianas College offers a nursing program with an Associate's in Nursing Science degree. Bachelor's and Advanced Practice degrees are accessible online. The social work, counseling, and psychology professions require supervision by senior-licensed individuals, but their numbers are limited on Saipan. The nearest US medical school is in Hawaii. There are currently no psychiatric residency or elective programs on Saipan. The Department of Emergency Medicine has had senior residents visit for away electives. The recruitment of American Board-certified physicians in some subspecialties has led to the recent creation of regulations allowing qualified foreign- licensed providers to obtain medical licensure to practice in the CNMI. The practice of psychiatry in Saipan is influenced by local laws that allow for Civil Involuntary Commitment. Commitment must be based on "clear and convincing evidence of an individual posing imminent (within the past 24 hours) risk of harm to themselves or others." Commitment can also be sought if their level of function shows "grave disability." Individuals who are committed can be detained initially for up to 72 hours of evaluation. If there is a continuing concern, the Attorney General's office may then apply to the court for an initial commitment of 14 to 30 days, based upon evidence of dangerousness from the past 14 days. This commitment can be renewed for 60 days twice for a maximum of 123 days.

The main public hospital on Saipan, the Medicaid-certified Commonwealth Healthcare Corporation, was established in 1978. Of its 86 beds,10 are part of a locked adult psychiatric inpatient unit. Adolescent psychiatric inpatients are kept in the adjacent pediatric unit with psychiatric nursing staff, and their parents or guardians are requested to be present in the unit. Those in need of inpatient care on the two more populated islands, Tinian and Rota, arrive by small propeller plane after 15 to 40-minute flights, or by boat for a few hours if the weather is bad. Inpatient services are provided by one of three psychiatrists, who rotate weekly for coverage and call. They also provide outpatient, emergency, and consult liaison services. Recruitment in the past has been difficult at times, requiring coverage by internal medicine and telepsychiatry if a psychiatrist could not be recruited. As there is no long-term Forensic psychiatric hospital, inpatient restorations of competency are occasionally provided at the hospital as well. Psychoeducational testing for special education is available until age 25.

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With three current psychiatrists, the ratio of psychiatrists to the population is 1:15,775, compared to Idaho, which has the most significant disparity at 1:13,709.

Medications are shipped to the hospital and two retail pharmacy chains on Saipan. Some medicines are sent from the hospital in Saipan and out to Tinian and Rota. However, there are supply chain challenges with medications. For example, a patient with symptoms of mania was more than a month late in receiving a paliperidone 156 mg injection. They needed the starting paliperidone 234 mg dose, but delivery to the island would take a week. The only available dose was Paliperidone 156 mg. With limited published information, multiple psychiatrist consultations, and discussion with their family, given their decompensation warranted injection with Paliperidone 156 mg as it would provide some stabilization, and they would receive Paliperidone 234 mg after a week to complete the standard medication loading. Medication side effects of hyperhidrosis on an SNRI and bruxism from an SSRI are a couple of rare medication side effects that have come up while providing treatment.

Cooperation with researchers from other countries has helped. For example, doctors at the De La Salle Health Sciences Institute Das Marinas, Carrie in the Philippines, shared a Tagalog translation of the Vanderbilt Attention Deficit Hyperactivity Disorder Symptoms Scale filled by parents about their children. This scale in Tagalog has helped parents to better identify symptoms for diagnosis and treatment. There is a need in the territories for statistics and advocacy with voting legislators to continue improving services. Stigma about mental illness extends beyond that of Western medicine. This leads to extended delays in seeking treatment with therapy and medication, as recommended. Family trees are complex blends of multiple generations. Some may describe family members with symptoms, but they are often refused access or contact with Western psychiatric evaluations and treatments. With a history of provider turnover, those who are able to see a provider consistently over several years have expressed appreciation and offered gifts of locally grown fruit, like bananas, papayas, mangos, and avocados.

Conclusion: There are psychiatrists working in rural and underserved areas on tropical islands in the western Pacific, surrounded by clear, warm, saltwater, in a US territory. Recruitment for additional psychiatrists is ongoing at: https://www.chcc.health/saipandoctors

Acknowledgment of Indigenous Largesse: This is an acknowledgement that The Commonwealth of the Northern Mariana Islands (Sankattan Siha Na Islas Mariånas in Chamorro and Commonwealth Téél Falúw kka Efáng llól Marianas in Carolinian) is an indigenous place whose original people are today identified as Chamorro and Refaluwasch.

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The Commonwealth Health Care Corporation is located on the island of Saipan (Saipan in Chamorro and Sáaypéél in Carolinian). We further recognize that generations of indigenous Chamorro and Refaluwasch and their knowledge systems have shaped Saipan in a sustainable way that allows people to enjoy the island's gifts. In return, immigrants express gratitude to the archipelago and its people.

Citations by request.

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Specialization in Child and Adolescent Psychiatry in Serbia

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The specialization in Child and Adolescent Psychiatry has existed as a distinct medical discipline in Serbia since 1993. It lasts four years (48 months) and is conducted in clinics, institutes, hospitals, and departments of psychiatry and child psychiatry, as well as in mental health centers and dispensaries within primary healthcare institutions.

The Ministry of Health announces calls for applications for this specialization, which can be either institutional (based on the needs of the healthcare institution employing the candidate) or voluntary, at the request of the individual candidate, depending on the current needs of the country. The Faculties of Medicine in Belgrade, Niš, and Novi Sad are responsible for organizing and implementing the specialization program.

Part of the specialist training, lasting up to 12 months (one year), may be completed in institutions outside the Faculty of Medicine, provided that the relevant organizational units and departments meet the legally prescribed professional, infrastructural, and staffing criteria. The remaining 36 months, dedicated exclusively to child and adolescent psychiatry, must be completed within the teaching bases of the Faculty of Medicine. For some candidates, this requirement entails relocation to one of the aforementioned cities. The training schedule is jointly developed by the candidate and the mentor, with mandatory rotations within and between the teaching institutions. The mentor must have at least five years of experience as a certified specialist and must fulfill the eligibility criteria defined by the Faculty of Medicine.

The specialization in Child and Adolescent Psychiatry focuses on inpatient and outpatient psychiatric care for children and adolescents, as well as on the assessment, diagnosis, and treatment of various psychiatric disorders in accordance with internationally recognized classification systems. The program fosters close internal collaboration with experts in pediatrics, child neurology, and adult psychiatry, while external collaboration includes cooperation with educational institutions (preschools and schools), social welfare services, and the judicial system. The quality of training is ensured through continuous supervision and periodic assessment of

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the residents' progress via colloquia. During the specialization, candidates are required to complete five mandatory and five elective colloquia. Mandatory colloquia are: propaedeutics (Medical Psychology), Psychopathology and Phenomenology, Developmental Disorders, Behavioral and Emotional Disorders Specific to Childhood and Biological Therapeutic Methods and Psychotherapy. Elective colloquia include various areas such as substance use disorders in children and adolescents or forensic child and adolescent psychiatry.

The specialization consists of two components: Core Module (36 months) - the candidate rotates through the following units: Outpatient psychiatric care for children and youth – 12 months, Day hospital for children – 3 months, Day hospital for adolescents – 3 months, Inpatient psychiatric care for children and youth (including intensive treatment units for children and adolescents) – 12 months, Developmental neurology – 3 months, Pediatrics – 3 months. Complementary Module (12 months) covers Psychotherapeutic procedures – 4 months, Adult psychiatry – 4 months, Forensic psychiatry – 2 months and Treatment of addiction disorders – 2 months

To date, 62 professionals have successfully completed the specialization in Child and Adolescent Psychiatry in Serbia, including trainees from the Republic of Srpska and Montenegro, where they currently live and work. The goal of the specialization program is to ensure that child and adolescent psychiatry specialists develop strong communication skills and uphold high ethical standards. The most powerful diagnostic and therapeutic tool in psychiatry remains an individualized approach to each patient.

Given the growing global needs in the field of child and adolescent mental health, it is essential that Serbia significantly increase the number of trained specialists in this area.

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Reforming Mental Health Education in Ukraine: Lancet Psychiatry Commission

Viktoriia Kolokolova[1], Iryna Pinchuk[2] [3]

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[3] Ukrainian Psychiatric Association

The Lancet Psychiatry Commission is an international panel of experts convened by The Lancet Psychiatry to produce evidence-based analyses and policy recommendations on critical global mental health challenges. The Lancet Psychiatry Commission on Mental Health in Ukraine was established to assess the country's current mental health needs and develop a reform plan aligned with international standards and grounded in human rights (DOI: 10.1016/S2215-0366(24)00241-4) (1). The Commission was officially launched on 9 October 2024 during the WHO Mental Health Forum at the organization's headquarters in Geneva, Switzerland, with the event streamed live via the WHO website.

In a nation grappling with the immense psychological toll of war, Ukraine is undertaking a foundational reform of its mental health care system, guided by the All-Ukrainian Mental Health Program "How Are You?", an initiative spearheaded by First Lady Olena Zelenska. A series of expert consultations convened by the Coordination Center for Mental Health under the Cabinet of Ministers of Ukraine, in close collaboration with the authors and advisory board of the Lancet Psychiatry Commission, has emerged as a pivotal forum for operationalizing strategic recommendations and advancing their practical implementation.

That morning 10 July 2025, the decision to shift the Fourth Consultation to a fully online format was made in response to a devastating Russian missile and drone attack on Kyiv during the preceding night. The bombardment—part of a series of increasingly intense assaults—left at least two people dead and dozens wounded, with residential neighborhoods and essential infrastructure under fire. Despite this harrowing backdrop, Ukrainian and international experts gathered virtually to define a transformative vision for mental health education, underscoring the profound urgency driving the reform.

Viktoriia Kolokolova, representing the Coordination Center for Mental Health of the Cabinet Ministers of Ukraine and co-author of the Lancet Psychiatry Commission, emphasized in her opening remarks that these essential reforms are being advanced under the conditions of ongoing war and daily threat. She framed the consultation within this urgent reality, highlighting the need to bridge the Lancet Commission's strategic vision with practical steps for European integration and the implementation of new, real-world educational models. As Dr. Kolokolova stressed,

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> "I want to remind you of the context in which the system...and specifically the system of specialist training, is transforming and changing."

The Strategic Need for Reform

The consultation commenced with opening remarks from Professor Iryna Pinchuk, chair of the Lancet Psychiatry Commission, who systematically outlined the foundational challenges undermining Ukraine's current mental health education system. Among the most pressing issues identified were:

- **Fragmentation:** A persistent lack of interdisciplinary collaboration permeates all levels of the system, from national ministries to local service providers.
- **Absence of a National Strategy:** There is no coherent workforce plan to guide the development of the number and types of professionals needed to deliver the new, community-oriented model of care.
- **Obsolete Paradigms:** Educational programs remain rooted in formal knowledge acquisition, with insufficient emphasis on the cultivation of practical, real-world competencies.
- **Discrepancies with European Standards:** Postgraduate training programs continue to lag behind European norms, highlighting a significant misalignment with contemporary standards.
- **Peer Support Deficit:** Although recent progress has been noted, formalized training opportunities for individuals with lived experience remain limited.

Expanding on these points, Stanislav Chumak, co-author of the Lancet Psychiatry Commission and member of the Education Working Group, described the "isolation of the education system," wherein programs for psychiatrists, psychologists, and social workers function in separate silos. This structural separation is further exacerbated by a paucity of practical training opportunities within community settings, limited uptake of digital learning modalities, and the ongoing stigma that renders psychiatry an unattractive specialty for many students.

Charting a New Course: Recommendations and Alignment

The consultation delineated a strategic roadmap for advancing mental health workforce development in Ukraine, emphasizing the necessity of harmonizing educational standards with international best practices and embedding competency-based, practice-oriented training models.

European Integration

Dr. Marisa Casanova Dias, co-author of the Lancet Psychiatry Commission, President of the Psychiatry Section of the European Union of Medical Specialists (UEMS), presented a comprehensive framework for aligning Ukraine's postgraduate psychiatric education with the European standard. Central to this vision is the transition from the existing two-year internship to a five-year residency program, as recommended by UEMS to ensure both the depth and quality of specialist training.

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Dr. Dias highlighted that UEMS offers a robust suite of resources to support this process, including quality assurance evaluations for training centers and a newly established European board examination, for which Ukrainian trainees are now eligible. She underscored that the ultimate objective of harmonization is not mere standardization, but the elevation of training quality across all contexts:

> "The goal of harmonization is to level all up—not just to create uniformity."

Evidence of Reform in Practice: Emerging Models from the Field

The panel discussion illuminated concrete examples of how international standards and innovative practices are being embedded into Ukraine's mental health system.

Peer-to-Peer Support

A peer support model, particularly among veterans, has become a cornerstone of psychosocial rehabilitation efforts. Denys Bardachenko, a veteran and active participant in the program, shared that his decision to join stemmed from a desire to adapt to civilian life and reframe his traumatic experiences as a resource for others. As he expressed:

> "My loss, my experience is in no way a burden; on the contrary, it is a resource and an instrument."
> Bardachenko further articulated the ethos of this approach:
> "Support is not about pity, it's about partnership."

Echoing this sentiment, Mykyta Baburkin, who leads the peer support department at the Superhumans Center, underscored that their work is fundamentally patient-driven, with outreach efforts aimed at reducing stigma around war-related injuries. The educational outreach project for academic institutions was established in direct response to the stigma and fear veterans with injuries often face in society. Covering more than 770 institutions—from kindergartens to universities—it has delivered age-appropriate educational events for children and young people. These sessions aim to provide gentle, accessible information about trauma and to teach respectful, informed ways of communicating with and relating to individuals with injuries.

mhGAP Integration

Andriy Burdeinyi presented the successful integration of the WHO's Mental Health Gap Action Programme (mhGAP) into the undergraduate curriculum at Bogomolets National Medical University. This initiative is pivotal in equipping future healthcare professionals with essential competencies for managing common mental health conditions, thus fostering greater tolerance and reducing stigma throughout the medical field. To date, over 300 students have completed this training, highlighting its early impact.

As part of the ongoing reform of Ukraine's mental health system, the WHO's Mental Health Gap Action Programme (mhGAP) has been established as a cornerstone intervention at the primary health care level. Since

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1 January 2025, mhGAP has been formally included in the list of mandatory competencies for primary care physicians, ensuring that early detection and basic management of common mental health conditions become an integral part of routine medical practice. To date, more than 114,000 family doctors, pediatricians, general practitioners, and nurses across the country have received mhGAP training, significantly expanding the capacity of the primary care workforce to deliver mental health support directly within communities.

Multidisciplinary Teamwork

Anna Koba, WHO consultant and trainer of mobile multidisciplinary teams, emphasized that true multidisciplinary collaboration extends far beyond simply collocating different specialists, highlighting clear communication, mutual respect that dismantles professional hierarchies, shared goals, and ongoing supervisory support as key enablers of effective teamwork.
Koba highlighted innovative training approaches, such as case-based role-play in which professionals assume the roles of other disciplines, which have proven highly effective in cultivating a genuinely collaborative mindset.

Challenges and International Perspectives

The trajectory of mental health reform in Ukraine is shaped by significant legislative and institutional barriers. Professor Iryna Pinchuk identified ongoing challenges, including disparities in remuneration for educators across disciplines, which complicate efforts to establish unified, multidisciplinary training programs.

Despite these obstacles, international partners voiced strong support and offered valuable perspectives. Professor Norman Sartorius, WPA past president and the member of the Advisory Board of the Lancet Psychiatry Commission, emphasized the importance of critically re-examining the evolving landscape of mental health needs to better orient training priorities, and advocated for the active involvement of carers—not only as beneficiaries but as educators for health professionals. Professor Bennett Leventhal, co-chair of the Lancet Psychiatry Commission, described the move towards multidisciplinarity as

> "profoundly important to excellence in practice,"

Throughout the consultation, a shared conviction emerged: the foundation of a resilient and contemporary mental health system in Ukraine lies in its capacity to cultivate a new generation of professionals. Despite the formidable challenges posed by ongoing conflict, participants and international experts expressed deep respect for Ukraine's determination and progress.

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The Human Factor in International Affairs

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On April 4, 2025, at the Embassy of Italy in Washington, DC, the WPA Conflict Management and Conflict Resolution (CMCR) section co-sponsored the annual gala of the Washington Psychiatric Society (WPS), a district branch of the American Psychiatric Association. This writer, the 2024-2025 WPS president and 2023- 2026 CMCR co-chair, organized and led the symposium: The Human Factor in International Affairs.

The symposium featured: Gabrielle Rifkind, a group analyst who specializes in backchannel diplomacy, international mediation, and conflict resolution as the founding director of the Oxford Process; Ambassador (Ret) Luigi Einaudi, a past Acting Director of the Organization of American States, who successfully negotiated the conflict between Ecuador and Peru in 1998; Prof. Amir Afkhami, M.D., Ph.D., Vice Chairman of the department of psychiatry at the George Washington University, who planned and led the U.S. State Department's Iraq Mental Health Initiative (IMHI) and the psychosocial components of the Afghanistan Civilian Assistance Program (ACAP-II), along with other national-level programs to mitigate the mental health consequences of conflict and mass violence against civilians.

This symposium was a tribute to Gianni Picco, an extraordinary international civil servant, who passed away in 2024. As an Assistant for Political Affairs to the UN Secretary General Javier Perez De Cuellar, Picco negotiated the Soviet withdrawal from Afghanistan, the end of the Iran-Iraq war, and the rescue of Western hostages in Lebanon.

In 2014, Picco and Rifkind co-authored The Fog of Peace: The Human face of Conflict Resolution. They wrote that war is perpetuated by the failure to manage the humiliation of defeat. Those of us living in conflict look for safety blankets. We take on collective identities that can be ethnic, religious, and cultural. Societies are governed by laws, devise systems of arbitration, reconciliation, in order for citizens to coexist. However, in conditions of heightened tension, we are driven by rigid beliefs about identity. As part of large groups, we become consumed by the histories of our groups. We identify with collective earlier traumas, which the psychoanalyst Vamik Volkan has referred to as “chosen traumas.”

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Conflict is more likely to be resolved when the geopolitical complexity is placed in a bed of human relationships. Conflict resolution is better served "at the kitchen table" according to the Swedish diplomat Hans Blix. This is not therapy, but human motivations and emotions should be part of the strategic equations. Empathy is neither appeasement nor sympathy. Empathy is a skill that can be acquired and honed, not a trait that can only be inherited.

The field of conflict resolution originated in the mid-20th century, when social scientists applied theories of international affairs and labor relations to international conflicts. In 1981, Dr. William Davidson, a psychiatrist, and Joseph Montville, a US diplomat, coined the term “track II diplomacy,” describing it as: "unofficial, informal interaction between members of adversarial groups of nations with the goals of developing strategies, influencing public opinion, and organizing human and material resources in ways that might help resolve conflicts.” In 1996, Louise Diamond and John McDonald developed the concept of multi-track diplomacy, identifying nine tracks to engage various governmental and non-governmental actors in peace- making activities. In addition, “track 1.5 diplomacy” and “backchannel” are terms used when official and non- official actors operate under the instructions of government officials.

Open-minded, altruistic, unofficial representatives and third parties run small, informal dialogues, problem-solving workshops. They explore underlying causes and alternative ideas, while maintaining access to official decision-makers. New approaches are discussed not only between groups, but also within groups. Participants try to change the perception of the others, but are also open to changing their own perspective by addressing the psychological aspects of the disputes. The goal is to prepare the ground for the transition of ideas to track I, the official diplomacy, government to government, state to state.

In 1931, Albert Einstein wrote an open letter to Sigmund Freud, asking why there is war and what can be done to prevent it. Freud lukewarmly responded that aggressive instincts are inherent to the human condition. In 1968 the American Psychiatric Association founded a task force on psychiatry and foreign affairs, chaired by Dr. Davidson. Subsequently, the task force became a standing committee, active through the 1980s and focused on the Arab-Israeli psycho-political relationship and other conflicts. In 1977, the Egyptian President Anwar Sadat addressed the Knesset, the Israeli parliament, stating: "There remains another wall. This wall constitutes a psychological barrier between us, a barrier of suspicion, rejection, fear, deception..."

In 1969, Senator William Fulbright, known around the world for the Fulbright scholarship, then Chairman of the US Senate foreign relations committee, held a series of Senate hearings on the psychological aspects of foreign policy. He stated, ”It is believed by many that wars start in the mind of men...yet an examination of the human mind...to understand our own political behavior has not appealed to either the public or to political leaders...It may be that we are frightened by the possibilities that might be revealed by some self-examination.”

Foreign policy-making emerges from a nation’s perceptions and misperceptions of itself and other nations. Policymakers and psychiatrists must work together to manage international conflicts. As psychiatrists, we must

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contribute to developing psychologically minded, empathetic approaches to international relations. We must offer our advice to the subject matter experts of diplomacy and statecraft.

Conflict is part of the human condition. It is ubiquitous and universal. It is intra-personal, interpersonal, national, and international. It manifests in stark and brutal forms in the international arena. It cannot be negated, avoided, or eradicated but it can be at times ameliorated. Hope and hard work in the pursuit of conflict management and resolution must not cease.

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Artificial Intelligence in Psychiatric Education: Opportunities, Challenges, and Implications

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I. Introduction

The influence and future of artificial intelligence (AI) continues to be broadly discussed, potentially touching almost all facets of life. Knowledge production, dissemination and integration are core to education and of course education in psychiatry. Students and teachers already are leading in many ways. Artificial intelligence (AI), particularly generative AI (GenAI) and large language models (LLMs), has emerged as a promising adjunct to psychiatric education by enhancing clinical competence and simulation (Lee et al., 2025; Gill & Galletly, 2025). However, psychiatry faces unique educational challenges as it requires nuanced interpersonal skills and complex biopsychosocial reasoning (Elkrief et al., 2025; Lee et al., 2025).

We know that traditional educational methods, including lectures, role-plays, and standardized patients, often struggle with scalability, consistency, and exposure to rare or complex cases (Ajluni, 2025). This introductory paper discussed the applications, benefits, limitations, and ethical considerations of AI integration in psychiatric education, as well as strategies for future implementation. Despite its rapid adoption, in this paper we will not address is the use of AI in therapeutic situation.

II. Rationale for AI Integration in Psychiatric Education

There are well recognized limitations of traditional psychiatric education. Lectures often overload learners and fail to cultivate adaptive reasoning (Elkrief et al., 2025) while role-play and standardized patient encounters are resource-intensive, difficult to scale to real life experience, and may not expose trainees to rare conditions (Ajluni, 2025). Important to the World Psychiatric Association (WPA) there are limited global mental health resources and rising mental health needs exacerbate the training gap (Lee et al., 2025; Zheng & Zhang, 2025).

However, there are opportunities offered by AI. AI can generate diverse, realistic psychiatric cases, enhancing exposure to rare and complex disorders (Lee et al., 2025; Prégent et al., 2025). For the WPA, these rare cases can be made available for study to psychiatrists around the world at no extra cost. In addition, AI enables safe practice in high-risk scenarios, such as suicide or acute psychosis, without endangering patients or traumatising trainees (Ajluni, 2025).

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III. Applications of AI in Psychiatric Education

Evidence from institutions like Yale University and Massachusetts General Hospital shows reduced student anxiety, increased self-efficacy, and improved diagnostic accuracy (Ajluni, 2025). AI can be integrated with VR to further enhance realism (Ajluni, 2025; Zheng & Zhang, 2025). Generative AI can produce unlimited case scenarios, multiple-choice questions, and Script Concordance Tests to facilitate case- based learning (Lee et al., 2025; Prégent et al., 2025). These can be adapted to local cultural practice, making their transferability seamlessly. AI-curated modules deliver foundational knowledge asynchronously, allowing faculty to focus on reasoning and practiced supervision (Elkrief et al., 2025). The need for large group or classroom learning diminishes and can make that time available for discussion or debate, rather than didactic learning. By simplification of complex psychiatric concepts, AI aids student comprehension and study efficiency (Lee et al., 2025). AI assists in generating assessment materials, including reasoning-focused tests that measure decision-making rather than factual recall (Lee et al., 2025; Elkrief et al., 2025). There remain risks of "hallucinatory" material and thus distorting the testing and scoring of tests. For these and other reasons supervisor-led assessments are preferred in AI-mediated educational contexts to ensure authentic skill evaluation (Gill & Galletly, 2025). We agree that formal AI literacy should recommended as a core competency for psychiatric trainees, covering LLM functionality, ethical considerations, and safe clinical use (Gill & Galletly, 2025; Torous et al., 2025). This AI literacy means understanding limitations, identifying bias, and interpreting outputs critically to avoid over-reliance (Zheng & Zhang, 2025).

IV. Challenges and Ethical Considerations

There are issues with accuracy and reliability. AI outputs can include hallucinations, oversimplifications, and errors requiring faculty oversight (Lee et al., 2025; Prégent et al., 2025).

Generative AI may reflect bias in datasets, impacting minority representation (Lee et al., 2025; Zheng & Zhang, 2025). Privacy and legal constraints may mean that patient data cannot be entered into public AI tools without explicit consent due to privacy and confidentiality concerns (Gill & Galletly, 2025). Over-reliance on AI may undermine development of empathy, communication, and therapeutic alliance skills (Zheng & Zhang, 2025). Ethical concerns include high costs, paywalls, and limited infrastructure may create inequities in access to AI-enhanced educational tools (Ajluni, 2025; Lee et al., 2025).

V. Future Directions

We expect that psychiatry will expand research on AI's educational impact, including outcomes on clinical reasoning, empathy, and patient care (Lee et al., 2025; Prégent et al., 2025). What will follow is that there will be integration of AI with VR/XR, natural language processing, and adaptive learning systems to simulate realistic clinical environments (Ajluni, 2025; Zheng & Zhang, 2025). Of course, our educational models and focus will need to change as we cultivate dual competency: producing technical fluency with AI and enduring humanistic care to prepare psychiatrists for AI-augmented clinical practice (Zheng & Zhang, 2025). Our trainees and teachers are using AI, banning or limiting their use will ultimately fail. We need to get a better sense of how they are used and develop policy and procedures around and within their use. There are massive risks, but the tide cannot be stopped. Hence, we actively need to address equity, privacy, ethical, and regulatory concerns to ensure safe and responsible AI adoption globally (Torous et al., 2025; Zheng & Zhang, 2025).

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VI. Conclusion

In our view AI has transformative potential to enhance psychiatric education by supplementing traditional methods with simulation, personalized learning, and efficient content creation (Ajluni, 2025; Lee et al., 2025). There however remain limitations and risks, including bias, privacy concerns, and potential erosion of humanistic skills, require careful supervision and faculty guidance (Prégent et al., 2025; Zheng & Zhang, 2025). Successful integration depends on active-learning frameworks, AI literacy training, and global standards (Elkrief et al., 2025; Torous et al., 2025). As a profession we need to rapidly catch up with what's happening on the ground. Ultimately, AI should serve as a supportive partner in psychiatric education, creating clinical competence while preserving the core values of empathy and human connection (Zheng & Zhang, 2025).

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Empowering Early Career Psychiatrists: Global Education, Equity, and Innovation through the WPA ECP Section

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Introduction

The WPA Section of Early Career Psychiatrists (ECPs) is a global, diverse community of psychiatry trainees and psychiatrists within 7 years of specialisation or subspecialisation. Today, the Section includes 259 active members, 54 alumni, and 49 allies (medical students and other mental health professionals) across all WPA regions. Its mission is to empower early-career professionals through education, collaboration, and leadership development. The Section's work aligns with the WPA Action Plan, the WHO Comprehensive Mental Health Action Plan 2013–2030, and the United Nations Sustainable Development Goal 3, reinforcing the principle that improving mental health outcomes depends on equitable access to high-quality training and professional support.

Global Challenges in Early Career Psychiatric Education

Despite increased recognition of mental health worldwide, young psychiatrists continue to face major disparities in training opportunities. In some regions, structured supervision, mentorship, and research training are limited or inconsistent. Educational activities are often offered as isolated lectures or webinars that spark interest in the moment but lack continuity or sustained support. Meanwhile, early-career psychiatrists are expected to teach, supervise, conduct research, and manage clinical responsibilities, often without training in teaching methods, leadership, or academic writing. These gaps contribute to frustration, reduced confidence, and unequal access to professional development. The WPA ECP Section addresses these challenges by fostering sustained mentorship networks, peer learning, and long-term capacity building rather than one-off events.

Educational Mission and Core Values

The Section views education as a collaborative, culturally informed, and continuous learning process. Its work is grounded in equity, transparency, and innovation, with the aim of preparing psychiatrists who can integrate scientific knowledge with empathy, cultural understanding, and ethical practice. Participation in the Section allows members to contribute to the development of new educational models, build leadership skills, and forge regional and international partnerships that shape the future of psychiatry.

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Key Educational Activities and Programs
The ECP Section carries out a wide range of initiatives designed to strengthen both professional and personal development.

Global and Regional Webinars
The Section organises regular global and regional webinars that provide a platform for early-career psychiatrists to present their research, discuss new clinical developments, and exchange experiences across borders. These sessions foster peer learning and create opportunities for visibility and professional recognition.

Educational Presence at the World Congress of Psychiatry (WCP)
At each World Congress of Psychiatry, the ECP Section develops interactive sessions that encourage exchange, creativity, and skill development. The Difficult Cases Session promotes collaborative clinical reasoning and cultural reflection. The WPA Quiz offers an engaging, team-based learning environment that combines knowledge and collegiality. The 3-Minute Research Competition supports the development of concise and impactful scientific communication. These events allow ECPs to gain confidence in presenting, teaching, and participating in international dialogue.

Leadership through Participation
Leadership development is a central part of the Section's mission. Members are encouraged to take on roles in committees, working groups, and project coordination. Through these responsibilities, they gain experience in international team collaboration, conflict negotiation, planning, and communication. Participation in the Section thus constitutes experiential leadership training, enabling early-career psychiatrists to shape initiatives while developing the competencies required to lead mental health systems.

The World Psychiatry Exchange Program (WPEP)
The WPEP enables early-career psychiatrists to complete short-term placements in psychiatric institutions abroad. To date, the program has supported more than 40 exchange participants across eight countries since 2022. These placements provide exposure to diverse models of care and cultural approaches to mental health. Participants return with strengthened clinical adaptability, greater cultural attunement, and an expanded international professional network. Importantly, the program promotes fairness in access to global training, particularly benefiting colleagues in low- and middle-income countries.

Research and Mentorship Development

Two new initiatives are currently being launched as part of the Section's 2025–2028 Action Plan. The ECP Research Learning Program will provide structured guidance in research methodology, study design, data interpretation, and scientific writing, supporting early-career psychiatrists in developing and disseminating academic work. In parallel, the ECP Mentorship Program will connect younger colleagues with senior clinicians

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and researchers who can offer career advice, guidance in professional decision-making, and emotional support. Together, these initiatives reinforce the Section's commitment to long-term professional and personal development.

Addressing Inequities and Emerging Challenges in Psychiatric Education

The Section's activities respond to ongoing challenges such as unequal training conditions, workforce shortages, digital transformation, migration, and cultural diversity. Many ECPs cross borders to pursue education or employment and may need additional support to navigate unfamiliar healthcare systems. Others work in settings where psychiatric resources remain limited. Through global networks and shared learning, the Section promotes equity, resilience, and a sense of professional belonging.

Building the Future of Psychiatric Education: The 2025–2028 Vision

Looking ahead, the Section aims to expand its digital learning platforms, strengthen mentorship networks, support research development, and foster local and regional leadership. A major goal is to organise a Global ECP Conference that will highlight innovative practices, collaborative projects, and the diverse perspectives of early-career psychiatrists worldwide.

Conclusion

The WPA Early Career Psychiatrists Section is more than a professional network—it is a global educational movement shaped by the diversity, creativity, and commitment of its members. Through its mission and programs, the Section bridges inequalities, fosters excellence, and inspires a generation of psychiatrists to lead with empathy, knowledge, and purpose. As psychiatry continues to evolve in response to global challenges, the ECP Section remains steadfast in its goal: to ensure that education is not only a path to competence but also a force for equity, compassion, and innovation in mental health worldwide.

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What Path Do Psychiatrists Follow to Specialize in Mexico?

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Globally, the path physicians must follow to become specialists is long and demanding. Achieving that goal can often resemble running an obstacle course. In Mexico, medical school is highly competitive. Approximately 270 undergraduate medical programs exist nationwide (ANUIES). However, access is unequal: public universities offer limited seats, whereas private institutions charge high tuition fees. Costs vary widely—from free in state-run schools to as much as 135,000 USD for the five-year degree in private institutions.

Upon completing their undergraduate studies, many graduates wish to pursue postgraduate training to become specialists; however, some specialties are more sought after than others. In Mexico, interest in psychiatry has increased over recent years. The number of applicants has grown, particularly after the COVID-19 era, which brought renewed visibility to the crucial importance of mental health (González de la Cruz, 2018; López-Iñigo, 2020). Despite this trend, the country remains far from having enough psychiatrists to meet the needs of its population.

One reason psychiatry may be less frequently chosen is that undergraduate students rarely receive meaningful exposure to the discipline. In most universities, the psychiatry course lasts only 15 to 30 days. Furthermore, teaching is often theoretical and offers little clinical experience. Although human connection is a defining characteristic of psychiatry, undergraduate students rarely have the opportunity to engage directly with patients. Such contact—with individuals who live with mental disorders, who carry complex personal histories, who experience pain and distress, and whose clinical course can genuinely be transformed through psychiatric care—could positively influence specialty choice. If we could emulate, even modestly, what storytellers such as novelists or filmmakers achieve—supported by real experiences and scientific knowledge—we would likely motivate more students to pursue psychiatry.

Economic incentives also influence specialty choice. Young physicians often feel drawn toward “greener pastures,” opting for higher-paying surgical specialties. In Mexico, private psychiatric consultations typically range from 50 to 200 USD, whereas public-sector psychiatrists earn between 1,500 and 3,500 USD per month.

In contrast, even a relatively simple cosmetic procedure performed by a plastic surgeon can far exceed these figures. In 2025, 65,000 physicians applied for a specialty position, yet only 15,000 obtained a placement. Approximately 450 positions will be allocated to psychiatry next year (CIFRHS).
Currently, 1,295 Mexican and 65 foreign trainees are enrolled in psychiatry residency programs across 38 accredited hospitals. Residents receive a stipend of approximately 1,000 USD per month, with which they must cover their living expenses, as their training requires full-time employment. Given this context, it is not surprising that the number of psychiatrists trained each year remains insufficient. According to the Ministry of Health, the country has 4,500 psychiatrists (Secretaría de Salud,), most of whom are concentrated in the three largest cities: Mexico City, Guadalajara, and Monterrey. Because specialized mental health professionals are scarce, mental health care in Latin America is often delivered by psychologists and nurses (World Health Organization, 2025). According to the OECD, between 12 and 15 psychiatrists are recommended for every 100,000 inhabitants, yet Mexico has only 3.4 (OECD). As a result, many individuals are unable to receive timely, adequate mental health care. After completing residency, job opportunities in public institutions are limited, as few positions are available. Additionally, retirement-related vacancies have not been consistently incorporated into workforce planning for several years. Workloads in the public sector are heavy—a psychiatrist may see up to 18 patients during an eight-hour shift—which contributes to the decision many psychiatrists make to shift to private practice, where they care for fewer patients. Ultimately, this leads to the same outcome: limited and insufficient care for the most vulnerable populations.

This assessment is not meant to be pessimistic; rather, it reflects the need to remain aware of Mexico's current situation in order to guide meaningful change. Although public policies aimed at improving the health-care system are being implemented, significant work remains.
Nonetheless, there is reason for optimism. Despite the challenges inherent in psychiatry training, those who pursue and later practice this specialty demonstrate a genuine commitment to improving care and contributing to the mental health of the Mexican population.

Acknowledgments

My gratitude to Dr. Sophia Sanchez-Lopez for the valuable information she provided.

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