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

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

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Chair's column

Prof. Anthony Guerrero (Hawai'i)

Chair, Child and Adolescent Psychiatry Section, World Psychiatric Association

Happy, peaceful, and prosperous New Year to everyone!

It is once again my sincere privilege and pleasure to introduce this edition of World Child and Adolescent Psychiatry (World CAP), the official newsletter and e-journal of the Child and Adolescent Psychiatry Section of the World Psychiatric Association (WPA-CAP). I want to give special kudos and gratitude to Editor, Dr. Flávio D. Silva (Brazil), and Deputy Editor, Dr. Tomoya Hirota (Japan-USA), for their diligent work on this edition.

In this edition, we pay tribute to a wonderful colleague and contributor to the WPA-CAP section, Dr. Takahiko Inagaki. We hear from global colleagues in Canada, Israel, the U.S.A., Indonesia, Ecuador, Brazil, and Norway: covering timely topics that include lifespan health, infant psychiatry, social isolation, Attention-Deficit Hyperactivity Disorder awareness, child and adolescent psychiatric training, early career perspectives, and WPA education activities. We thank our Editor and Section Secretary, Dr. Flávio Dias Silva, for the summary of the WPA-CAP section's activities at the 2024 WPA Congress in Mexico City. We thank all WPA-CAP section members for their presentations and contributions.

World CAP continues to serve as an important venue for "improving child and adolescent mental health by connecting global wisdom with everyday practice and advocacy," and the editorial team invites you to connect with the authors and other colleagues involved in the featured work, and to submit articles on topics that can stimulate further dialogue and knowledge advancement. World CAP also serves as an important publication for keeping WPA-CAP members and other global colleagues informed about WPA-CAP activities.

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Since the last update, WPA-CAP, together with the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP), the World Association for Infant Mental Health (WAIMH), and the International Society for Adolescent Psychiatry and Psychology (ISAPP), has been involved in the planning of the forthcoming World Infant, Child, and Adolescent Mental Health Day (WICAMHD). Modeling after the success of last year's (https://iacapap.org/events/world-infant-child-and-adolescent-mental-health-day/wicamhd-2024.html) and previous year's events, 2025's WICAMHD first ever hybrid in-person and online symposium will feature the theme: "Bridging Worlds: Mental Health support for Displaced Children and Families," and will be strategically held in partnership with the Turkish Association of Child and Adolescent Psychiatry (TACAP)'s 34th National Congress of Child and Adolescent Mental Health and Illnesses in Turkey. Please stay tuned for further details, and please check https://iacapap.org/events/world-infant-child-and-adolescent-mental-health-day.html for periodic updates.

WPA-CAP also intends to support, through interested volunteer representatives of our organization, the efforts of the IACAPAP and the Child Mind Institute (CMI) in The Global Child and Adolescent Psychiatry Curriculum Project, which will be a core curriculum for child and adolescent psychiatric training worldwide.

We invite you to make sure you are an active member of the Child and Adolescent Psychiatry Section (https://www.wpanet.org/_files/ugd/842ec8_51fd0f0629184f059cc88f671893ede5.pdf) and if not, to formally join the Section (https://www.wpanet.org/join-a-wpa-section). We would also welcome your participation in other activities of the Section, including quarterly member meetings via video-tele-conference, collaborations around presentation submissions and networking events at various international meetings, and collaborating in a Project ECHO® forum focused on global challenges in child and adolescent mental health. We also invite you to review our Section's materials, including all past World CAP issues, which can be found at https://www.wpanet.org/child-adolescent-psychiatry.

Happy Readings!

Prof. Anthony Guerrero (Hawai'i)

Chair, Child and Adolescent Psychiatry Section, World Psychiatric Association

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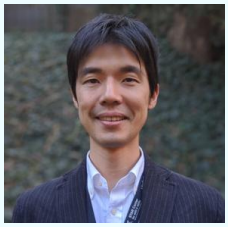
Editor's column

Flávio Dias Silva, MD, MSc (Brazil)

Tomoya Hirota, MD, (USA/Japan)



Dear colleagues,

As we step into the first issue of 2025, we are delighted to bring you another installment of our e-journal, continuing our mission to foster collaboration and innovation in the field of Child and Adolescent Mental Health (CAMH). Reflecting our commitment to diversity, this issue—like the last—showcases an array of topics that span research, clinical practice, local initiatives, career development, and training. Our content is designed to resonate with a global audience, including CAMH professionals, trainees, and other stakeholders dedicated to improving the mental health of young people.

We are profoundly grateful for the contributions of authors from various regions, including Asia, the Middle East, North and South America, and Europe. These voices add a rich tapestry of perspectives that inspire our readers to "think globally, act locally." This approach is crucial for addressing the complex and diverse challenges faced by youth worldwide, particularly in the evolving landscape of mental health care.

Looking ahead, we aim to expand our reach and engagement. We warmly encourage trainees and professionals in CAMH to share their insights and experiences through our e-journal. By serving as a hub for networking and knowledge exchange, we hope to foster stronger connections across borders, disciplines, and cultures.

Together, we can continue to advance the field and better serve youth experiencing mental health challenges. Let's make 2025 a year of progress, collaboration, and meaningful impact in CAMH.

Happy readings!

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Invitation to submit

World Child & Adolescent Psychiatry is published by the Board of the Section of Child and Adolescent Psychiatry. It is a non-commercial, non-profit vehicle that welcomes articles from all members of the Section who wish to share their interests, news or scientific findings. To take part, simply express your interest to the editors and we will be happy to guide you. Our contact e-mails are available on the last page of the e-Journal. Get involved!

A World Child & Adolescent Psychiatry é publicada pela Direção da Secção de Psiquiatria da Infância e da Adolescência. Trata-se de um veículo não comercial e sem fins lucrativos que acolhe artigos de todos os membros da Secção que desejem partilhar os seus interesses, notícias ou descobertas científicas. Para participar, basta manifestar o seu interesse aos editores e teremos todo o prazer em o orientar. Os nossos e-mails de contacto estão disponíveis na última página da revista eletrônica. Participe!

World Child & Adolescent Psychiatry es una publicación del Consejo de la Sección de Psiquiatría del Niño y del Adolescente. Es un vehículo no comercial y sin ánimo de lucro que acoge artículos de todos los miembros de la Sección que deseen compartir sus intereses, noticias o descubrimientos científicos. Para participar, simplemente exprese su interés a los editores y estaremos encantados de orientarle. Nuestros correos electrónicos de contacto están disponibles en la última página del e-Journal. ¡Participe!

World Child & Adolescent Psychiatry est publié par le conseil d'administration de la section de psychiatrie de l'enfant et de l'adolescent. Il s'agit d'une publication non commerciale et à but non lucratif qui accueille les articles de tous les membres de la section qui souhaitent partager leurs intérêts, leurs nouvelles ou leurs découvertes scientifiques. Pour participer, il vous suffit d'exprimer votre intérêt auprès des éditeurs et nous nous ferons un plaisir de vous guider.
Nos adresses électroniques de contact sont disponibles en dernière page de l'e-Journal. Participez !

يرغبون الذين القسم أعضاء جميع من بالمقالات ترحب ربحية وغير تجارية غير وسيلة وهي .والمراهقين للأطفال النفسي الطب قسم مجلس قبل من والمراهقين للأطفال النفسي للطب العالمية المجلة نشر يتم
توجيهك وسيسعدنا للمحررين اهتمامك عن التعبير سوى عليك ما، للمشاركة .العلمية نتائجهم أو أخبارهم أو اهتماماتهم مشاركة في.
!شارك .الإلكترونية المجلة من الأخيرة الصفحة في الإلكتروني البريد عبر معنا التواصل يمكنكم

World Child & Adolescent Psychiatryは、児童青年精神医学部門の理事会によって発行されています。本誌は非営利・非商業的な媒体であり、関心事やニュース、科学的知見を共有したいセクションの全メンバーからの記事を歓迎します。参加を希望される方は、編集部までご連絡ください。
連絡先のEメールは、電子ジャーナルの最終ページに掲載されています。参加する

World Child & Adolescent Psychiatry世界兒童與青少年精神病學》是由兒童與青少年精神病學分部理事會出版。這是一份非營利、非商業性的刊物，歡迎所有希望分享其興趣、新聞和科學發現的分會會員提供文章。如果您想參與，請聯絡編輯室。
聯絡電子郵件可在電子期刊的最後一頁找到。參與其中！

World Child & Adolescent Psychiatry diterbitkan oleh Dewan Bagian Psikiatri Anak dan Remaja. Jurnal ini bersifat non-komersial dan nirlaba yang menerima artikel dari semua anggota Seksi yang ingin berbagi minat, berita, atau temuan ilmiah. Untuk ikut serta, cukup ungkapkan minat Anda kepada para editor dan kami akan dengan senang hati memandu Anda. E-mail kontak kami tersedia di halaman terakhir e-Journal. Bergabunglah!

विश्व बाल एवं किशोर मनोचिकित्सा को बाल एवं किशोर मनोचिकित्सा अनुभाग के बोर्ड द्वारा प्रकाशित किया जाता है। यह एक गैर-वाणिज्यिक, गैर-लाभकारी माध्यम है जो अनुभाग के सभी सदस्यों के लेखों का स्वागत करता है जो अपनी रुचि, समाचार या वैज्ञानिक खोजों को साझा करना चाहते हैं। भाग लेने के लिए, बस संपादकों को अपनी रुचि व्यक्त करें और हमें आपका मार्गदर्शन करने में खुशी होगी। हमारे संपर्क ईमेल ई-जर्नल के अंतिम पृष्ठ पर उपलब्ध हैं। शामिल हों!

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An honorable colleague

Dr Takahiko Inagaki (09/07/1975 – 05/11/2024)

It is with great sadness that we, colleagues at the World Psychiatric Association, recently learned of the death of our dear colleague Dr. Takahiko Inagaki.

Takahiko Inagaki was born in Osaka, Japan on 09 June 1975. He graduated from Shiga Medical University, School of Medicine in March 2004. He completed the initial clinical training for medical graduates at Chidoribashi Hospital in Fukuoka-city in April 2006. He returned to Shiga Medical University Hospital to train as a psychiatrist and then became an Assistant Professor there. After he worked at Shiga Medical University Hospital for a total of 10 years, in April 2016, he moved to Shiga Psychiatric Medical Center where he spent two and a half years as a Chief Psychiatrist. Then, he started working as Head of the Division of Adolescent Psychiatry of Biwako Hospital in Shiga prefecture in October 2018. He has worked hard to establish a local network of mental health professionals for children and adolescents in the region. He was passionate about early detection and appropriate treatment of childhood depression. He participated in the Effectiveness of Guidelines for Dissemination and Education in Psychiatric Treatment (EGUIDE) project and worked tirelessly to promote appropriate pharmacotherapy.

Takahiko was a colleague who was very present in the projects of WPA CAP Section in recent years, as well as in the International Association of Child and Adolescent Psychiatry and Allied Professionals (IACAPAP). With his dedication, respect and empathy, he always captivated his colleagues. He was a person committed to what he did, and enthusiastic about developing ideas about innovations in care systems. A few months ago, for example, he was accepted to present a symposium at the IACAPAP Congress in Brazil, which would bring together colleagues from that country, but also from Kenya and Mongolia. In addition, over the last decade, Takahiko dedicated himself to other activities in our Congresses, and fantastic work in the translation of the IACAPAP e-Textbook - an important resource in our field.

Truly, the loss of our dear Dr. Inagaki is felt by fellow psychiatrists from various parts of the world. We wish Dr Inagaki rest in peace and send condolences to his family.

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Research communications

What do Lifespan Health, the World Psychiatric Association Sections, Adverse Childhood Experiences, Clinical Outcome Measurement, Big Data, Medical Education, and Global Curriculum Development Have in Common?

David Cawthorpe, Canada.*

*https://profiles.ucalgary.ca/david-cawthorpe.

Dr David Cawthorpe

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Introduction

In Comorbidity of Mental and Physical Diseases: A Main Challenge for Medicine of the 21st Century (Sartorius, 2013), Sartorius underscores the critical interconnection between mental and physical health, highlighting the frequent coexistence of these conditions and their impact on diagnosis, treatment, and outcomes. Sartorius (2013) calls for "appropriate management of comorbidity – at the individual and at the public health level – will require a significant reorientation of medical education and a reorganization of health services."

Seven years after the formation of the WPA Multimorbidity Section, at the 2024 World Psychiatric Association meeting, the presentation "What Do Adverse Childhood Experiences, Multimorbidity, & Big Data Have in Common?" [https://youtu.be/73V9azPuRbc] explored how early adversity, multimorbid conditions shape healthcare outcomes. Employing a 16-year dataset consisting of about 100 million diagnoses in approximately 750,000 individuals, advanced analysis demonstrated the lifespan association of mental disorder and complex biomedical multimorbidity based on the single assumption that early adversity is one gateway to subsequent psychiatric diagnosis.

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Big Data and Adverse Childhood Experiences (ACE)

A Novel Population-Based Health Index for Mental Disorder (Cawthorpe, 2013) quantified the prevalence and costs of psychiatric conditions in a population over 16 years. Analysis revealed that over 50% of the population had at least one psychiatric disorder and on average had three times more biomedical disorders than those without any psychiatric disorder diagnosis. Similarly, about 30% of children and adolescents had a psychiatric diagnosis and about twice the biomedical disorders compared to children without any psychiatric diagnosis (Wilkes et al., 2012).

In an associated study of large regional, clinical, child and adolescent population, Cawthorpe et al. (2018) analyzed the relationship between ACE survey responses and psychiatric diagnoses. While ACE scores showed limited association with specific psychiatric diagnoses, they had a palpable relationship with psychiatric urgency scores on the Western Canada Waitlist Children's Mental Health Priority Rating Score (WCWL-CMH-PCS: Cawthorpe et al., 2007; Novick et al., 2016). This study primarily highlighted the immediate need to formally integrate ACEs information into psychiatric assessment, treatment planning, and clinical outcome measurement – a call for a standard of care change that has to date failed to register and remains unheeded in clinical undergraduate training or continuing medical education (Smith, 2025).

Trauma Assessment, Diagnosis, and Care Planning

Trauma assessment should precede psychiatric diagnosis and inform treatment planning, particularly in populations with higher (>2) ACEs. Unaddressed trauma may lead to misdiagnoses and lack of response to treatment, and hence poorer outcomes. By integrating trauma assessments, clinicians can accurately contextualize symptoms, enabling targeted interventions. Trauma-informed, trauma-focused, and trauma-competent care reframes diagnoses from "what is wrong" to "what happened," reducing stigma and fostering engagement (Cawthorpe et al. 2018). Early trauma intervention is cost-effective, as untreated trauma frequently, notwithstanding psychiatric treatment (Cawthorpe & Davidson, 2015; Cawthorpe et al., 2018), results in comorbid conditions and their significant associated healthcare costs. Integrating into clinical workflows and training instruments like the ACE survey and the WCWL-CMH-PCS (Table 1), together with intelligent clinical outcome measurement (Chai & Cawthorpe, 2024) that accounts for multimorbidity-related interventions may lead clinicians to recognize the sequala of multimorbidity and treat trauma appropriately. Such advancement may optimize clinical outcomes, identify effective interventions, and possibly reduce long-term healthcare costs.

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Table 1: WCWL-CMH-PCS and WHO ACE survey items.

WCWL-CMH-PCS	WHO ACE
1. Danger to Self 2. Danger to Others 3. Psychotic Symptoms 4. Global Age-Appropriate Development 5. Children's Global Assessment of Functioning (CGAF) 6. Internalized Symptoms 7. Externalized/Disruptive Behavior 8. Co-Morbid Medical Conditions 9. Co-Morbid Psychiatric Conditions 10. Harmful Substance Use/Misuse 11. Biological Family History of Mental Illness 12. School/Work Problems 13. Social/Friendship/Community Functioning 14. Problems in Home Context 15. Family Functioning/Factors Affecting Child 16. Prognosis Without Further Intervention 17. Likely Benefit With Intervention	1. Emotional Abuse 2. Physical Abuse 3. Sexual Abuse 4. Emotional Neglect 5. Physical Neglect 6. Household Substance Abuse 7. Household Mental Illness 8. Parental Separation/Divorce 9. Household Domestic Violence 10. Household Member in Prison 11. Bullying 12. Community Violence 13. Peer Violence 14. Poverty 15. Loss of a Close Family Member 16. Discrimination 17. War/Conflict Exposure

The Need for Standard of Care Education

Incorporating mental health comorbidities into specialty training programs is essential for managing complex multimorbidity. One study analyzing training programs in 20 countries (Heinz, et al., 2021) revealed significant variability in mental health integration, with only four countries (Bangladesh, Serbia, the Netherlands, and France) embedding mental health in over 50% of specialties. In contrast, countries like Brazil and the U.S. included mental health in less than 20% of specialty programs. The need remains, as indicated by the COMET-G study spanning 40 countries (Fountoulakis et al, 2024) indicating that "psychiatry is the field with the most trans-specialty and interdisciplinary value and application points to the importance of teaching psychiatry and mental health in medical schools".

Addressing this disparity requires reorienting postgraduate training to recognize the interconnectedness of physical and mental health (Smith, 2025). Specialists across all medical disciplines need specialized training to identify psychiatric comorbidities and understand their implications for biomedical diseases. Embedding mental health and

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psychiatric disease awareness in curricula promotes interdisciplinary collaboration and equips clinicians to address the lifespan complexities of multimorbidity, especially when informed by the ACE survey (Swedo et al., 2024).

Standardized Measurement in Clinical Settings

Two manuals (Chai & Cawthorpe, 2022; 2024) provide practical resources for managing multimorbid conditions. The clinical manual offers structured protocols for integrated care, emphasizing multidisciplinary collaboration, care pathway algorithms, and standardized tools for documentation and assessment (Melathopolous & Cawthorpe 2019). The clinical manuals support clinicians in delivering evidence-based, personalized care while fostering continuous learning and adaptability.

The patient manual empowers individuals to manage their conditions through simplified guidance on symptom tracking, medication adherence, and communication with healthcare teams. By fostering patient engagement, the patient manual promotes shared decision-making and improves outcomes. Together, these manuals bridge gaps between clinical and patient-focused approaches, advancing holistic, data-driven healthcare.

Their real-world applicability also supports integrating patient-reported outcomes into medical education. By incorporating actual patient records into competency assessments, the manuals align training with practical challenges, preparing healthcare professionals for the emerging complexities of modern medicine (e.g., multimorbidity).

The Role of ACEs and Multimorbidity in Healthcare Innovation and Reform

The systemic implications of unmet physical and emotional needs, as highlighted by Bowlby, demand rethinking care models to integrate mental and physical health assessments. The presentation at the World Psychiatric Association emphasized the role of big data in addressing these gaps through trauma-informed treatment planning. The patient and clinician manuals along with practical instruments usable in both advanced and low-resource settings are instrumental to the called-for health care reforms (Sartorius, 2013).

This comprehensive approach bridges clinical care, patient engagement, and educational innovation, fostering better outcomes for individuals across their lifespans. By leveraging ACE-informed assessments and real-world evidence, healthcare systems can address the intertwined burdens of multimorbidity and early adversity.

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Conclusion

The interconnectedness of mental and physical health presents a pressing challenge for 21st-century medicine. Addressing comorbid and multimorbid conditions requires systemic changes in education, practice, and policy to integrate mental health into broader healthcare frameworks. Trauma-informed care and ACE-based assessments are critical for accurate diagnosis and effective intervention as concluded in this population-based global study (Osibogun, 2025).

The manuals by Chai & Cawthorpe (2022, 2024), independent of local resources, serve as guiding templates for advancing practice. Together with recent advances in big data analytics and Artificial Intelligence Assisted Large Language Models, it is possible to provide actionable frameworks for addressing these challenges. By fostering interdisciplinary collaboration and embedding real-world evidence into medical training, healthcare systems can innovate to meet the growing demands of practice in the face of emerging clinical challenges such as managing multimorbidity. This holistic approach, rooted in compassionate care and data-driven strategies, offers a pathway to improved health outcomes and reduced societal burdens. The integration of cross-section innovation is especially important for the WPA sections working on the development of modern global curricula, such as the WPA's Child and Adolescent Mental Health Section.

Afterword

In support of measuring intervention effect in the context of complex multi-morbidity, the following electronic educational guide book titled "Monitoring Clinical Outcomes In Western and Traditional Chinese Medicine will be available online at APPLE BOOKS for approximately 3 months from December 10, 2024 at no cost: http://books.apple.com/us/book/id6739160600

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Clinical Practice News

Infant psychiatry: core concepts and new theoretical clinical and ethical challenges.

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Dr Miri Keren (Israel)

Core concepts in infant psychiatry

Mental health across the lifespan is the capacity to experience, manage, and express a full range of positive and negative emotions, to develop trustful, close, empathic, satisfying relationships with others, and to actively explore environments and learn. All these take place in the context of one's family, culture and community. A wide epidemiological study (Egger et al, 2006) has shown that any psychiatric disorder may appear by the age of two years, except psychosis. Normal as well as abnormal development across childhood and adolescence is determined by a complex interplay between genetic, biological, psychological, cultural risk and protective factors and life events, in both the infant/child's and his/her close environment (Sameroff, 1985, 2004). Individuals do not simply vary in the degree to which they are vulnerable to the negative impact of adversity, but in their developmental plasticity for-better-and-for-worse: supportive experiences impact the plastic brain than the fixed brain. This has been named the Differential Susceptibility Model (Belsky & Pluess, 2009).

Environmental experience (exposure to physical and human environment) is now recognized to be critical to the differentiation of brain tissue itself. During the early years of life, the basic circuits of the brain are developing and are

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the substrate of mental processes, involving emotions, memory, behavior and interpersonal relationships. A developmental history of consistent and supportive care engenders secure attachment and early competence, which in turns, play a critical role in later adaptation (Luthar et Cichetti 2000, Sroufe 2005, Sameroff 2000). Parental insightfulness is a major factor of resilience, as it is the basis for sensitive, emotionally regulating parenting, is embedded in everyday routines; It includes both insight and empathy, as it is about being able to see things from the child's point of view, to think about motives, to have a balanced and multifaceted view of the child, to show openness regarding child and self, and to express acceptance (Oppenheim & Koren Korie,,,,). Secure and organized attachment is one more tenet of resilience, as it has been associated with better emotional regulation, more flexible cognitive functioning, better social and empathic relationships, better parenting and better physical health.

Parental psychopathology significantly impacts parenting. More important than the specific parental diagnosis is the way the illness impacts on parenting behaviors. More specifically, emotional detachment and under- involvement, as well as excessive control with hostility are especially detrimental to the young child.

The common reasons for referring an infant to a child psychiatrist are Feeding-eating disturbances, sleep disturbances, separation anxiety, developmental delays, excessive crying, irritability, psychomotor agitation, behavioral problems, aggression, trichotillomania, inadequate parenting, neglect, abuse, parental major psychopathology, withdrawn behavior, peers relational difficulties.

Diagnoses are given using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5, 2016). It is a multiaxial framework, based on the Transactional model. The young child's clinical symptoms are categorized into one or more Clinical Diagnoses (Axis I), based on algorithms of criteria. The quality of the observed young child's relationships with the main caregivers is noted on Axis II (Relational Context). The child's physical health and exposure to health-related stressors is noted on Axis III. The young child's environmental stressors (including parental psychopathology) are noted on Axis IV, and his/her developmental status in the motor, language, social, cognitive and emotional domains. This holistic, biopsychosocial formulation of the child's clinical status, with the identification of the specific weaknesses and strengths in both the child and his/her close environment, enables the clinician to plan for treatment.

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The treatment of very early psychopathology always involves both the young child with her/his caregivers, as the parents' inner world is enmeshed in the infant's one. Various dyadic (parent-infant) and triadic (both parents and infant) intervention strategies (ports of entry) have been developed over the years. A detailed description is beyond the scope of this paper but can be read in Zeanah (2019).

The 21st century challenges around parenthood and children's mental health

Huge advances in the field of procreative medicine have created both opportunities and risks. Indeed, parenthood and pregnancy are not necessarily one anymore: the parent may wonder whether he/she is the parent of this baby? And the child may wonder who are his/her "real" parents? For instance, IVF pregnancies are nowadays very common. Their pitfalls lead to complex societal, legal and ethical conflict, as the following example illustrates: A baby girl, fruit of an IVF pregnancy, was born prematurely because of a complicated heart condition. As part of her medical and genetic workup, it became obvious that the baby does not belong to the woman who delivered her! A "human error" happened at the lab and raised a long lasing debate at the Family Court about who is the "real" mother? The one with the womb and its biological characteristics that impact the fetus, or the "biological" one with the fertilized egg and genes? Who is the "real" father? Does the pregnant woman's husband has any right at all to claim fatherhood more than the "biological" father has? What is the best interest of the baby, in terms of her/his future uncertainty about her/his origins and identity? The first IVF baby was born in 1978. Over the last 20 years, there is the option of adding a screening step to the IVF process, named pre-implementation genetic screening (PGS) for diseases. Inherent to this screening is knowing the embryo's sex. Should parents be given this choice? What is the role of societal values? An additional and now common development of IVF techniques is the practice of surrogate pregnancies, that raises psychological, medical, ethical and legal issues. Indeed, surrogacy involves new parties in the process of reproduction and creates psychological risks (new relationships with third party partner, issues around rights, and responsibilities of both sides), medical risks to the surrogate or the fetus (including low birth weight, increased risk of multiple gestation, and preterm birth, hypertensive disorders of pregnancy, postpartum hemorrhage, and gestational diabetes), ethical and legal issues concerning the surrogate's autonomy, agency, rights and duties, as well as risks of coercion and exploitation. Nowadays, the laws regulating surrogacy differ widely between countries. Thus, psychological screening and support prior to, during and following surrogacy is indicated. Should it be provided automatically? Should it be mandatory? Preliminary data about altruistic surrogacy shows that most altruistic surrogacy arrangements are successfully implemented and most surrogate mothers are well-motivated and have little difficulty separating from the baby born as a result of the

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arrangement. The perinatal outcome of the children was comparable to standard IVF and egg donation and there is no evidence of harm to the children born because of surrogacy. Family relationships within the surrogate's own family seem to be good and the children are not negatively affected as a result of their mother's decision to be a surrogate. To our best knowledge, no study about the outcomes of commercial surrogacy has been published.

The next biotechnical development, though still utopic, could be procreation without humans, thanks to the procedure named ectogenesis, meaning extra-corporal gestation in an artificial womb, from the beginning to the end of pregnancy. Huxley (1932) in his famous book "Brave New World" had described it: In such a world, the notions of family, mother and father disappear, and sexuality is totally separated from procreation. The society/politicians decide what types of humans is in its "best" interest. In 2005, Atlan, a physician, biologist and philosopher, former member of the French National Committee of Medical Ethics describes how the potential development of an artificial womb will start with "pure" medical aims but may lead to huge societal changes. Such an artificial womb would be a kind of a biological incubator, sophisticated enough to fulfill the functions of the uterus (including the implantation phase), the placenta and the nutritive maternal functions, as well as the various stimulations usually provided by the pregnant woman. For the moment being, only during the first 5 gestational days and from the 24th week on, extracorporeal gestation is feasible. However teams from Japan and US have started to work on the Ectolife project (https://www.youtube.com/watch?v=O2RIvJ1U7RE) , under medical rationale of infertility due to uterine diseases. The artificial womb could then be used by the society, for avoiding abortions of unplanned and undesired pregnancies, for avoiding pregnancy and delivery, avoiding premature births, for designing "perfect babies" with the combination of an artificial womb, preconception genome selection (PGS). The addition of the technique of in vitro gametogenesis will enable babies totally unrelated to specific biological parents, like Aldous Huxley predicted!

Will the inner feeling of parenthood stay the same? Will humans want to be parents? Will the prenatal bonding process be the same? Obviously, I do not have answers to these questions, but I think we need to reflect on them and on their implications for our core concepts of parenthood, family, attachment, sexuality…

Beyond these issues around procreation, parenting and growing up in the digital and artificial intelligence era may be very challenging. For instance, two processes linked to the use of smartphones have been identified: "technoference", i.e. the interruptions of social interaction due to technology interference, and "immersion", that is the person's absorption" in the digital devices and withdrawal of attention from the environment and turning the gaze away from

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the present person. Immersion is the most problematic component, as it has been linked with decreased feeling of social connection, increased distraction, less enjoyment from direct communication, and decreased empathy during direct conversations. Recently, there is an increased awareness of the potential detrimental impact of parents' preoccupation with their smartphone while caring for their babies or young children and is termed "distracted parenting". Distracted parenting has been shown to impinge on parental sensitivity and responsiveness (essential to the formation of secure attachment relationship and to emotional regulation). Digital parenting is defined as how parents need to be engaged in regulating their children's relationship with digital media (parental mediation) plus How parents themselves incorporate digital media in their daily activities and parenting practices. Two types of parental mediation have been defined: restrictive mediation (reduces exposure and risks but limits the child's opportunities to develop mastery and digital literacy), more common among lower income and educated parents, and enabling mediation (co-use, active monitoring and technical restriction…), aimed at empowering children's digital literacy, more common among higher income and educated parents. Parents tend to prefer restrictive mediation but inconsistently, as they often use touchscreens as babysitters or as a system of reward and punishment for the child's behavior. Also, there is The pervasiveness of the internet and mobile media is giving rise to an emergent form of parenting, called "transcendent parenting" that includes oversharing of children's pictures and personal information on social media, increased reliance on parenting apps for advice, the use of wearable devices in order to calculate babies' health data and behavioral patterns, as well as to monitor the child's whereabouts. Together, these practices concur to an unprecedented datafication of children's lives and the potential impingement on the children's rights to privacy, as well as the right to be forgotten and to remove content they might feel constraining later. In the light of all this, we suggest to view media consumption in the same way as food consumption. It is all about moderation and choosing the right content and setting time limits. Further research is needed, although it is hardly feasible to find a control group of parents who do not use smartphones! Still, future longitudinal studies could systematically compare responsiveness and sensitivity among parents with high level of absorption in their smartphones with parents with low level of absorption, compare the effects of technoference versus absorption on parental sensitivity and mediation, compare the effect on mothers and on fathers' responsiveness and sensitivity, detection of factors that are linked with high levels of parental and child's immersion, and find out what are the aspects of smartphone use that can be beneficial to the parent-child relationship.

Finally, is the increasing role of robots and AI: are we entering a revolutionary phase like automobiles in the 20th century did? Japan has the highest number of industrial robots in the world. Over a quarter of a million robots are

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employed to reduce the high labor costs and support further industrial mechanization, as well as a solution to Japan's declining birth rate and shrinking workforce. Japanese engineers work on developing increasingly sophisticated robots with different functions, including a talking office receptionist, a security guard and even a primary school teacher. The newest model of domestic helper, AppriAttenda, is aimed at encouraging couples to have more than one child while doing less home chores! The characteristics of the humanoid Japanese robots include abilities to walks, talk, smile, blink, pout and express anger or surprise. The next step is to dare imagine robot caregivers: can artificial intelligence mimic the attachment system?! In other words, can a robot be a good-enough caregiver, with balanced frustration and gratification, emotional attune, sensitivity and responsiveness, mentalization and reflective functioning, empathy? We may be bewildered by this perspective, but children think differently! Children visiting a science center located in a major Western Canadian city were randomly selected to participate in an experiment set up. 184 children aged 5 to 16 years (M = 8.18 years) Content analysis revealed that a large majority would consider a friendship with the robot and participate in friendship-type behaviors with it.

Let's think about the pros! For some children, a robot-caregiver with a highly sophisticated artificial intelligence may be better than being raised by parents who are neglectful and abusive or by multiple and changing caregivers in foster care or in orphanages...

But let us not forget the cons! Robots might be able to classify emotions and respond with matching expressions but rearing a child requires cultural attune, the child's temperament, and so on. If children begin to personify robots as living creatures, they are susceptible to developing robotic understandings of humans, bereft of moral standing. If robots can understand human behavior and respond emotionally to us, we, and especially children, may develop misplaced trust in robots. Can the robot caregiver be programmed to be "good enough", thus teaching the young child to deal with frustration? May babies be aware that there is no genuine human heart beating under that well-constructed robotic exterior. Does it really matter? What types of parents would robot-cared children become?

Concluding thoughts: Our role as mental health clinicians in the 21st century may be to reflect upon and to investigate the following questions: Parenthood: Will it continue to be a value in itself? Pregnancy and motherhood: Is it still an essential part of womanhood? Can infants develop a real attachment relationship with a robot caregiver? Are psychoanalytic concepts, such as oedipal conflict, still relevant? Will humanoids replace humans or will humans use humanoids for positive aims? How should we integrate digitalization and robotics in our research and practice

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(documenting, updating medical records, synthesizing information (for ex. ChatGPT). Could a robot be a psychotherapist, and more specifically an Infant Mental Health clinician?! I personally think we have no choice but to reflect with an open mind and raise the theoretical, clinical implications and the ethical dilemmas created by the more and more "bold" biotechnologies.

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Social isolation, youth, and mental health: not just "small adults".

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Recent scholarship against the backdrop of the COVID-19 pandemic has sparked interest in the association connection between social isolation, loneliness, adverse health effects, and decreased life expectancy. Social isolation refers to the "objective state of having few social relationships or infrequent social contact with others'' and is distinguished from subjective feelings of isolation and loneliness.(1) While the association between social isolation and adverse health outcomes in older adults is well established and has elicited interest in the medical community (1), the literature connecting youth social isolation with various adverse health outcomes, including anxiety, depression, substance use disorders, post-traumatic stress disorder, suicidal ideation, delayed recovery from concussion, violent extremism, as well as poorer adult outcomes such as obesity and poor cardiovascular health, is emerging (2,3)

Young people's embeddedness within families and communities, as conceptualized in Brofenbrenner's Ecological Systems Theory (4) may require a different approach to assessing and understanding social isolation in youth when compared to adults. Young people depend on adults for care and decision-making and are thus inherently embedded in larger systems with implicit social relationships. Conversely, young people in adverse circumstances may be less able to get out of these circumstances than similarly situated adults.

Furthermore, social isolation may not just affect individuals but may be experienced at the level of whole families, for example, for geographical reasons such as living in a rural area; isolation due to a move or relocation; disability of a

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family member resulting in transportation challenges; or mental illness in a parent. Not surprisingly, parental loneliness and isolation is correlated with adolescent isolation and poor mental health (5). Even entire communities may experience social isolation, either as a result of natural causes, such as weather-related circumstances like extreme cold or heat, or due to structural policy reasons such as the creation of racially isolated neighborhoods from redlining that are associated with poorer health outcomes.

While variables such as family factors, mental illness, physical illness, and disabilities may predispose youth to social isolation, other characteristics may be context dependent. For example, a gender or sexual minority youth may experience social isolation in a community that does not support LBGTQ values. In other words, membership in a stigmatized group in a non-accepting community may be a risk factor for social isolation.

The relationship between social isolation and mental illness is likely bidirectional - with each predisposing and exacerbating the other. Youth with depression may neglect mental health promoting activities, such as exercise or socializing with friends and family, and those with social anxiety may avoid social interactions, in both instances, deepening their social isolation. Individuals with stigmatized disorders, such as primary psychotic disorders, may have difficulty making friends, not only due to the negative symptoms of their illness or the isolating nature of the symptoms, but also the stigmatized nature of some of their symptoms.

Compared to adults, youth social interactions and social relationships are more likely to be mediated by social media and other online activities. Research supports both positive and negative impacts of social media on youth mental health: excessive use may worsen anxiety and depression, but forming connections with other members of the same marginalized group may have positive effects. Contemporary understandings of social isolation must account for the impact of digital technologies. What health benefits does virtual social connection confer and how do these compare to social connection in the physical world? When does online activity increase feelings of social connectedness, and when does it cause further isolation?

Leveraging the systems that young people are already embedded within may help address the adverse impact of social isolation. Schools and community programs may help identify socially isolated youth and mitigate the harmful effects of social isolation by targeted interventions addressing risk factors such as stigma, increasing support available to isolated families and communities, or connecting individuals with mental illness to treatment. Primary care clinicians

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and other community-based clinicians may detect risk factors early and prevent adverse outcomes. In fact, the reduced interaction with school and primary care during the COVID-19 pandemic likely exacerbated social isolation.

There have been several initiatives to address social isolation in adolescents, and, more broadly, the fragmentation of communities. The Aspen Institute, for example, supports the Weave Project which "connects, supports, and invests in local leaders stepping up to weave a new, inclusive social fabric where they live." Other programs designed with interventions for specific at-risk youth have been noted to improve youth social connectedness (e.g. Trevor project for LBGTQ+ youth) (6).

Health professionals like child and adolescent psychiatrists, pediatricians, nurse practitioners and family medicine practitioners, who work in youth mental health, should consider their roles in addressing social isolation. As emphasized by the American Academy of Pediatrics' policy statement on "Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health", relational health is important and may be an important mitigating factor in the prevention of adverse outcomes from childhood toxic stress (7). It is paramount that we ask our young patients about social connections, partners with their families and communities to reduce social fragmentation and better understand and mitigate the consequences of social isolation on the bodies and minds of young people. As has been demonstrated in other medical conditions, children and adolescents are not just "small adults" - so it is with social isolation and its impact on health. The embeddedness of youth in families and communities, differential patterns of online and social media use, and likely other additional factors, call for the pediatric medical community to better characterize and assess this important physical and mental health risk factor in our patients.

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Child and Adolescent Mental Health around the World

Celebrating ADHD Awareness Month in Jakarta-Indonesia: Awareness is key.

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*Child and Adolescent Psychiatrist

Dr Tjhin Wiguna (Indonesia)

Attention deficit/hyperactivity disorder (ADHD) is a neurodevelopmental disorder that causes children to be inattentive, hyperactive and impulsive with greater frequency and severity compared to children of the same age. This condition also causes disabilities such as, inability to follow learning in class and in establishing a good relationship with peers or their surrounding environment. This situation certainly triggers a suffering experience for children because of the inability to realize what is happening to them. Inappropriate treatment from people around them who may also not understand what is felt by children with ADHD can worsen the condition. These uncomfortable experiences are actually truly realized by children, but they are less able or may be less successful in voicing them because of their young age and limited abstract thinking abilities. It could also be that they are able but are too worried to express what they feel or dissatisfaction with the treatment they receive considering that they are often labeled as 'naughty children', 'lazy children', or 'troublemaking children' so they may often assume that their voices are no longer trusted.

Every year in October is commemorated as ADHD awareness month and this year the theme is "awareness is the key". A very relevant theme today because ADHD is one of the neurodevelopmental disorders that are often found both in Indonesia and throughout the world. The global prevalence is said to be around 6-10% which means that there are around 6-10 children who may be identified as ADHD out of a hundred school-age children who participated in the study. With the high incidence rate and the existing biopsychosocial impacts, the question is whether we all understand, are aware of and can act appropriately towards children with ADHD. A study from Indonesia that published in the Asian

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Journal of Psychiatry in 2020, found that 56.8% of 384 people randomly selected in the community had poor and very poor knowledge and understanding of ADHD. Even though the majority of those selected in the survey had an education level above high school. The survey also found that 58.9% of 384 randomly selected teachers also had poor and very poor knowledge/understanding. This condition could be followed by their perception and attitude that is not good towards ADHD.

In another qualitative study conducted on parents who have children with ADHD in Jakarta-Indonesia, it was found that parents view children with ADHD as naughty children, like to disturb, tend to force their will, demand to always follow their wishes, can't sit still, are defiant, seek attention, are fussy, and are lazy to learn. All of these are negative perceptions, and it influences parents to act punitively, scold, impose harsh discipline, some even say they commit violence against their children, and feel sad because they don't know what to do. This condition can get worse if the child's academic achievement also declines over time or the parents are often called by the teacher. There are also parents who do not understand that ADHD is a neurodevelopment disorder that can be overcome if given proper medical or psychosocial treatment. Thus, it is not surprising that children with ADHD are not understood and are not taken to seek help or treatment until the child experiences difficulties or fails at school, which is certainly a little too late.

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Not to mention the myths related to ADHD circulating in the community, for example ADHD is not a disorder but is part of the normal behavioral development of children so that parents do not need to seek help. The real reality is that there are differences in brain development in children with ADHD compared to children in general, and there is a role of genetic factors that underlie this condition. The second myth is that children with ADHD are children who lack motivation, are lazy or stupid so they do not need medical treatment. The reality is that children with ADHD often experience executive function deficits that disrupt their ability to control and organize themselves so that they cannot continue to maintain their attention optimally so that symptoms of inattention, hyperactivity and impulsivity appear which of course require appropriate medical treatment. Another myth is that ADHD is a problem of inappropriate parenting patterns so that improving parenting patterns is the way to fix it. However, it is now understood for certain that ADHD is a disorder with a biopsychosocial background and research related to this clinical evidence has been widely published.

Therefore, increasing the knowledge, awareness, understanding, and attitudes of the community, including teachers and mental health professionals who work with children, needs to be expanded and clarified so that it can help children with ADHD to become more qualified. The Indonesian Ministry of Health in 2011 has issued regulations related to guidelines for early detection of ADHD (The Indonesian Ministry of Health Regulation Number 330/Menkes/PER/II/2011) so that it can be used by the wider community to carry out early detection, but it seems that it still needs to be echoed louder and more continuously. Therefore, the government and child mental health professionals need to make more persistent efforts to increase public literacy regarding ADHD. Thus, prioritizing positive evidence-based information supports diagnosis and emphasizes various interventions that can be applied both at home and at school.

On 23rd October 2024, for the first time Child and Adolescent Psychiatry Section-Indonesian Psychiatry Association celebrated ADHD Awareness Month in Jakarta. The activity was held at the car free Sunday morning at Jalan Thamrin-Sudirman, Jakarta. This activity goal is a direct campaign of ADHD to the community by giving ADHD talk show, spreading the ADHD posters and e-leaflet to people who joined the car free Sunday activities. Moreover, there was also individual with ADHD that came by and spontaneously gave testimonials about their condition, their medications or other treatments that have done. During the campaign, people can ask and participate in ADHD early detection survey. The participants were very excited because they can get information from the experts and individuals with ADHD. Many participants mentioned that this is what they need but could not find the exact and trustworthy source about ADHD.

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Thus, this campaign hopefully may increase their knowledge and understanding towards children with ADHD and they may also disseminate the e-leaflet to others. In addition, disseminating positive information from e-leaflet to the wider community including teachers, such as positive messages that are non-judgmental, namely that children with ADHD are basically the same as other children, only they have a way of learning, behavior patterns, or need a slightly different parenting approach because of their more unique characteristics so that this understanding is expected to reduce stigma both at home, schools and in other surrounding environments. Finally, we also note that everyone needs to realize that ADHD is not a choice but innate, therefore it is also our job to guard, help and brighten their future.

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Training in Psychiatry and Child and Adolescent Psychiatry in Ecuador: Realities and challenges.

Freddy Carrion Gonzales Suárez, MD, from Ecuador.*

*Child and Adolescent Psychiatry

Dr Freddy Suárez

Third world countries have important deficiencies in the health sector. Lack of resources, political problems, lack of job security, corruption and many other causes have led to dividing health care into public care with a poor quality of care and private care, of better quality, but with limited access due to its costs. Ecuador is one of these scenarios.

Amid the storm, mental health is one of the least attended areas; where, despite observing a progressive increase in psychiatric pathologies, there is a progressive reduction of resources and difficulties in the practice of the profession. If the is a gray scenario for general psychiatric care, the scenario is even more worrisome for child and adolescent psychiatric care.

General state of psychiatric care

The number of psychiatrists in Ecuador is variable and there are no statistics because an unidentified number of professionals have decided to migrate to different countries (due to problems of insecurity, lack of job opportunities and desire to offer a better quality of life to their families), others work in other activities and others have retired/deceased. By 2020 there was a registry of approximately 360 psychiatrists nationwide, in a country of 17,000,000 inhabitants and a rate of 2.1 psychiatrists / 100,000 inhabitants (WHO recommends a rate of 10 psychiatrists / 100,000 inhabitants). Most psychiatrists are in the 3 largest cities of the country (Quito, Guayaquil and Cuenca), 1 or 2 psychiatrists in medium-sized cities and no psychiatrists in small cities and provinces. At the same date, the number of child and adolescent psychiatrists at the national level was 12 specialists. Due to the notorious lack of child and adolescent psychiatrists, mental health care centers for minors are extremely limited (even in the psychiatry

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services of several state children's hospitals, only general psychiatrists work). The waiting time for an appointment with a psychiatrist can be several weeks, and for the few child and adolescent psychiatrists the waiting time is several months.

The division between public and private care.

Public health services have always suffered from a lack of qualified professionals, budget problems, lack of complementary tests, lack of medical supplies and drugs, and an infrastructure that is more than 50 years old (and poorly maintained). Patients must first request an evaluation by a general practitioner in the first level health centers, where the need for a specialist is assessed, and then they are referred to a second or third level center (hospital), where they are generally attended by an internist/pediatrician, who requests an appointment with a psychiatrist. This process can take several months. After being seen by the psychiatrist, patients will receive medication from the state's basic medication list, which has few psychotropic drugs. If the medication is not available, patients will have to buy it themselves (which is very often the case). If a patient is hospitalized or treated in an emergency department, he/she can receive a direct consultation with a psychiatrist and the waiting time is reduced.

Because of the above limitations, many people make efforts to seek care in private health services. A consultation with a psychiatrist can be arranged directly and the cost varies between $50.oo to $100.oo USD and medication (which can cost tens or hundreds of dollars). Many private hospitals have psychiatric services and there are specialized psychiatric clinics (5 in Quito, 5 in Guayaquil, 1 in Cuenca and 1 in approximately Santo Domingo de los Colorados). There are only 2 or 3 in Quito and 2 or 3 in Guayaquil for inpatient care of pediatric patients with pathology.

Training of specialists in psychiatry and child and adolescent psychiatry.

Since 1980, the Central University of Ecuador in Quito (state-run) opened the postgraduate program in Psychiatry, with a curriculum of 3 to 4 years of training and a production of 6 to 12 psychiatrists per year (there were years when the postgraduate program was closed due to lack of money from the Ministry of Health - the main provider of scholarships). In Guayaquil, another postgraduate program was opened sporadically, but now it is not active. In 2015 the postgraduate degree in Psychiatry was opened at the Universidad Tecnológica Equinoccial in Quito (private), with a production of 10 to 12 psychiatrists per year. In either of the institutions has it been possible to open a subspecialty or second specialty in Child and Adolescent Psychiatry (or any other psychiatric specialty). The training in psychiatric specialties is carried

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out either outside the country or in semi-presential or virtual master's degree programs (often without recognition by the institutions of higher education).

The pandemic and the lost opportunity

Due to the Covid-19 pandemic, the Ministry of Public Health (MSP) had to encourage the participation of health personnel in its units, offering permanent contracts to physicians who join the fight, in this way approximately 1,000 general practitioners obtained a contract, but when the pandemic ended, the need for general practitioners was reduced, so in 2022 the Ministry of Public Health organized working tables to launch the "project 1. 000-24", which consisted of the teaching department of the MSP creating curricula to open 8 public postgraduate programs throughout the country, where the MSP would make its centers available for practical teaching and the medical careers of the different universities would collaborate with the theoretical teaching; with the objective of training the 1,000 contracted general practitioners as specialists. Among the medical specialties contemplated was a postgraduate degree in psychiatry and the possibility of subsequently offering training in sub-specialties (including child and adolescent psychiatry). Unfortunately, this project ended abruptly due to a change of political actors, coupled with a growing economic crisis in the state.

2024 and the limitation to open the subspecialty in Child and Adolescent Psychiatry

Since 2022, the Pontifical Catholic University of Ecuador (PUCE) in Quito has been in dialogue with different specialists and subspecialists, designing a program to train subspecialists in Child and Adolescent Psychiatry, relying on the postgraduate department of the Department of Medicine and the Postgraduate of Pediatrics. Representatives of the Council of Higher Education rejected the project, alleging that a Medical School can offer a subspecialty in Child and Adolescent Psychiatry only if it has a Postgraduate Program in Psychiatry.

With this resolution, PUCE made the decision to open the postgraduate program in Psychiatry (which would currently be the third in operation) and after designing the curriculum (where much emphasis was placed on subjects of Child and Adolescent Psychiatry), it was approved by the CES in September 2024 and in March 2025 the first postgraduates would be called. Once the program was launched, the proposal to launch the first subspecialty in Child and Adolescent Psychiatry in the country would be reactivated.

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Trainee perspectives

A Brazilian early career psychiatrist perspective.

Dr Andrews D. Andrade, Dr Fellipe Campos**, from Brazil*

*Child and Adolescent Psychiatrist, recently graduated at the Federal University of Sergipe Residency Program
**Professor of Child and Adolescent Psychiatry at the Federal University of Sergipe, Brazil.

Professor Fellipe Campos

Dr. Andrew D. Andrade

Dr Fellipe Campos, interviewer: Hi, Dr. Andrews. In the name of WPA (CAP Section), I'd like to thank you for your time answering our questions. This brief interview aims to show worldwide the experience and perceptions of an early-career psychiatrist. Considering that you've just recently finished you Psychiatry program and already volunteers as a Psychiatry preceptor, would you like to start our conversation by introducing yourself to our readers?

Dr. Andrews: Hello, everyone! I appreciate the invitation for this talk, and hope to contribute with by short – but full of enthusiasm – experience in the last year. I am from Salvador-Bahia (Brazil), I moved Aracaju-Sergipe (Brazil) in 2013, where I studied medicine at Sergipe Federal University (UFS), and graduated in 2019. I've worked for 1 year, including COVID-19 pandemic front lines. Then I've passed the residence test and did psychiatry residency at Sergipe Beneficent Surgery Hospital (FBHC) and finished the residency in March 2024. I am currently a master's student at UFS Post-Graduation Program, where I've been studying quality of life and depressive symptoms in caregivers of autistic children. I'm also a psychiatrist in the "Psycho-Oncology" service at FBHC, where I'm also preceptor for the Tiradentes University Medicine Internship (UNIT), and teach theoretical psychopharmacology classes for the first-year Psychiatry residents at FBHC, in addition to working as a psychiatrist at Physical Rehabilitation Center (CER-II / CIRAS), and work as a general psychiatrist for Brazilian public health care system (SUS), countryside.

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Interviewer: Why choose Psychiatry? How did you come to this decision?

Dr Andrews: I liked Psychiatry and decided to study it during my internship in Psychiatry. However, after I graduated, I started to question this decision for a while until the COVID-19 pandemic hit and, seeing the mental suffering that the pandemic caused, I confirmed my intention to study Psychiatry. I took the exam right after and entered the residency.

Interviewer: Within Psychiatry, is there any area of practice that interests you the most? Why?

Dr Andrews: I like all areas in Psychiatry, but I'm more interested in Child and Adolescent Psychiatry (CAP). I'm still evaluating whether I'm going to do this R4 (fourth year of medical residence in Brazil, focused on CAP), no, but there's quite a good chance.

Interviewer: How is your first year as a psychiatrist going?

Dr Andrews: Right after finishing my residency, I started taking the main classes for my master's degree, and this meant that I didn't reduce my workload right away, and I ended up maintaining a workload like the residency period for a few more months. I soon managed to get some jobs in clinics in the region, and I started working as a preceptor in the Psychiatry residency. I ended up getting fewer private practice patients than I had imagined at the time, but considering what I was able to do, I believe it was a more positive year and even exceeded my expectations.

Interviewer: You volunteered as a preceptor in your first year of working as a psychiatrist: what motivated you to become a residence preceptor?

Dr Andrews: I volunteered to be a preceptor in my first year of residency for a few reasons: first, I wanted to give back to the residency something I had received, which is the caregiving attitude, and I want to perpetuate this idea of caring for the residents. I know that the residency has a long workload and is difficult, but my preceptors welcomed us and understood the resident's needs, and this ends up reinforcing that I should reciprocate the care I received. In addition, it is also a great opportunity to keep on studying, because one of my fears as I was finishing the residency was to eventually end up "out of track", obsolete, so becoming a preceptor keeps me active, studying and always up to date, to contribute in the best way possible to the residents.

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Interviewer: You are currently studying for a master's degree at Sergipe Federal University Post-Graduation Department. How is your life of studying/teaching/clinical practice?

Dr Andrews: So, this life of studying, teaching and clinical practice is very rough, it's quite busy, that's why I don't attend at my office daily, and I only increased my office time since last month, and I'm not teaching as much as I wanted either, because it only takes one shift a week to teach psychopharmacology, despite all the time I have to prepare classes and study teaching methods and things like that. Furthermore, studying andragogy actually is also part of the master's degree, so it turns out that both of these demands were quite useful. In relation to the master's degree itself, I'll confess that I was going to get through it a bit with a struggle. There were some moments when I had to rush more than I should have, in order to complete some demands. I had a lot of difficulty during the mandatory classes because of time, and I had to sacrifice some of my time, especially during our mandatory subjects, like fun time and even sleep time, in order to be able to accomplish everything I had aimed to accomplish.

Interviewer: As a former resident and current preceptor, what do you consider to be the strengths of your PRM, and what do you consider to be its limitations?

Dr. Andrews: I consider the residence very welcoming, especially in comparison to other residences in other regions. A residence service in which the resident works very close to the preceptor and can experience the conducts very closely. We were always placed under training and, since my first day of residency, I have already seen patients, I have had a certain "handling training", I have been placed under evaluation by the preceptors very closely, already adjusting practical details, such as interview and medical conduct, and this part gave me particular joy ever since the beginning. About limitations, I would say: few vacancies for residents every year. Also, the fields of practice – even considering a good training variety – are often repetitive because there are not so many residents to rotate our training cycles, so the maximum rotation one can do is two stages per year, which means I stayed training for at least six months in each service. It turns out that some services have the idea of becoming quite repetitive.

Interviewer: Any decisions or strategies that you would've already changed at the beginning of your career as a preceptor and master's student?

Dr. Andrews: Regarding the strategy or decision to start a career as preceptor and a master's student, the timing for my master's degree was excellent, because I already had many demands for the degree just as soon as I've finished my

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residency, and luckily I didn't have so many things in my practitioner office yet to occupy my time, so I had a lot of free time to worry about the master's degree, which ended up consuming my free time. I wonder that, if I was already established in the Psychiatry market, if I already had more shifts in my office, it would probably be difficult to be able to fulfill master's degree agenda. Regarding to preceptorship, I've noticed some points that I could adjust in terms of teaching a group of residents (first-year residents), which has only two, now three residents, so a very small group, as well as my class structure, my teaching program in psychopharmacology was quite extensive, so next year (2025) I'm going to make some changes. I believe that this year was also a ground-one year for me as a preceptor, a year of testing myself in this new job. I've liked it so far, and I've learned a lot of things that I can put into practice next year, to improve my preceptorship, including learning from my own mistakes during this last year.

Interviewer: What is your outlook for your Psychiatry residency program and other Psychiatry programs around the country?

Dr. Andrews: First, I think that specialists and medical residences, not only in psychiatry but in many other areas, are going through a process of devaluation. I say this because many doctors end up acting as specialists without being so. First, we need to think about what make a general practitioner study hard and continuously, taking a residence entrance exam which is more competitive every year, submitting oneself in a two, three or more-year residency program, working at least 60 hours a week to earn a scholarship diploma. What's going to justify all this effort, if someone else do any lame post-graduation, start calling themselves specialists and nothing is done about this. So, you know, it's frustrating. I hear from residents that they've been unmotivated. So, this situation is worrying. If we go to any other professional field, like an airplane pilot, if instead of taking several courses, one simply gets on the plane and takes flight, calling oneself a "pilot". We know how complicated that would be.

Interviewer: Any tips for other Psychiatry residents who want to be preceptors?

Dr. Andrews: Regarding some tips for residents willing to become preceptors, I think it is quite noble. It is a situation of delivery of return of the residence itself for a service that was provided. It is important to remember that the preceptor is usually not paid for this role. So, I became a psychiatrist because there were other psychiatrists who volunteered to teach me the craft. Another tip that I can give is that if the opportunity arises, take it. Being a preceptor is an excellent chance not only to return to the residency but to expand yourself in the job market, as an updated professional,

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considering that we always need to study a lot to be able to teach the residents. Constantly studying keeps us always updated. This is a very healthy for the residence program, and for preceptors individually, such as me.

Interviewer: Thank you so much, Dr Andrews, for your time. It's been an honor to be working with you, and a great pleasure to talk to you about these experiences and perceptions. We, from CAP-WPA, wish you a great new year, full of joy and accomplishments.

Dr. Andrews: Thank you for inviting me, and Happy New Year to WPA team and all members and readers around the globe!

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Educational opportunities

The new WPA Education & Psychiatry e-journal. *Dr Norbert Skokauskas, from Norway*.*

* WPA Secretary for Publications and Education 2023-2026. Honorary chair of the WPA Child and Adolescent Psychiatry Section. Professor at the Norwegian University of Science and Technology (NTNU), Trondheim, Norway.

Dr Norbert Skokasukas

The Education & Psychiatry e journal, launched under the auspices of the World Psychiatric Association (WPA) in 2024, serves as a global platform dedicated to enhancing the education and training of mental health professionals. The journal operates under the guidance of the WPA Education and Scientific Publications Committee, which plays a critical role in shaping its direction and content. This committee oversees the development of WPA's educational programs, including the preparation and implementation of continuing medical education accreditation, as well as the formulation of publication policies and materials. The Secretary for Education and Scientific Publications, Prof. Norbert Skokauskas, serves as the journal's editor.

The journal brings together a diverse international editorial board and contributors to address pressing challenges, share innovative practices, and foster collaboration in psychiatry education worldwide.

The primary mission of Education & Psychiatry is to provide a comprehensive overview of psychiatry education across diverse contexts. By fostering dialogue among educators, practitioners, and policymakers, the journal aims to enhance the quality and accessibility of psychiatric training globally, promote innovative and evidence-based educational practices, and encourage collaboration and mutual learning across regions and cultural contexts.

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Over its first two issues, the journal has published contributions from a wide range of countries. Contributors hailed from Australia, Croatia, Dominican Republic, Egypt, El Salvador, Guatemala, India, Indonesia, Italy, Japan, Kazakhstan, Lithuania, Moldova, Nepal, New Zealand, Paraguay, Senegal, South Africa, Ukraine, and the United States.

These insights underline the unique challenges and opportunities in psychiatry training across different socio-economic and cultural landscapes. Articles often delve into groundbreaking topics, such as the integration of artificial intelligence in psychiatry education, the use of digital mental health tools, and the development of online learning resources for managing addictive disorders.

The journal also aims to promote key publications that advance mental health education and practice.For instance, it has featured books like Volunteering in Global Mental Health: A Practical Guide for Clinicians and Digital Mental Health: The Future Is Now, both of which offer practical insights and innovative perspectives for educators and practitioners.

The journal actively promotes awareness of important events in the field of psychiatry education, aiming to connect global audiences with key happenings. Through detailed event coverage, such as the psychotherapy workshop for South Asian psychiatrists, it highlights the importance of collaboration and ethical considerations in mental health care.

The Education & Psychiatry journal strives to bridge gaps in psychiatric training by sharing best practices and fostering global dialogue. The Education & Psychiatry journal invites educators, researchers, and practitioners from around the world to share their insights, experiences, and innovations.

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Meeting reports

The 24th WPA World Congress in Mexico. *Dr Flávio Dias Silva, from Brazil*.*

* WPA Child and Adolescent Section Secretary. Professor at the Federal University of Tocantins, Brazil.

Last November, the 24th WPA World Congress of Psychiatry was held in beautiful and welcoming Mexico City, a formidable event attended by more than 3,600 participants from 90 countries. The program featured over 148 sessions, 700 speakers, and 70 short Oral Poster sessions, reflecting the global breadth of expertise within the worldwide WPA community with 147 psychiatric associations and 250 000 members.

Child and Adolescent Psychiatry was a frequent topic of presentations and discussions, whether through the participation of our Section members, collaborative symposia with other Sections (such as Perinatal Psychiatry and Infant Mental Health), or even through the initiative of colleagues from all over the world who brought reports of studies and experiences to share with everyone. Here is a list of some of these presentations:

Course (in Spanish): Psicofarmacologia en la infancia y adolescencia ¿Que debemos saber? *Dra Carolina Herrera, Dra Betriz jaime and Dr Ilia Espindola-Jaramillio*

Scientific Session: New models of care for infant and perinatal psychiatry. *Dr Miri Keren and Dr Sam Tyano*

Scientific Session: Influencing the influencer: Digital selves, social media and the mental health of young people. *Dr Anish Dube and Dr Howard Yee Liu as moderators*

Distinguished Lecture: ADHD in Children and Adolescents.? *Dra Carolina Herrera and Dr Victor Rodriguez*

Plenary Session: A global perspective on prevention and treatment of mental health disorders in Youth. *Dr Miri Keren and Dr Celso Arango.*

Scientific Session (intersectional): Linking infant psychiatry to child and adolescent psychiatry. *Dr Flávio Dias Silva, Dr Tomoya Hirota and Dr Miri Keren.*

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Dr Flávio Dias Silva, Dr Tomoya Hirota and Dr Miri Keren.

There were also fifteen short oral poster presentations, ten in English and five in Spanish. We highlight the participation of WPA CAP Section member Dr. Freddy Gonzalo Carron Suarez, with the theme *'Perception of Mental Pathologies and Suicide in young people from Cotacachi community in the north of Ecuador*'.

We hope that this report will encourage colleagues who are specialists or especially interested in Child and Adolescent Psychiatry to prepare to submit their work to the 25th World Congress of Psychiatry, which will be held in Prague, Czech Republic, in 2025. Submissions are now open via the following link https://wcp-congress.com/. The deadline is **11 February**!

Long live our colleagues who are dedicated to improving the mental health of our children and adolescents!

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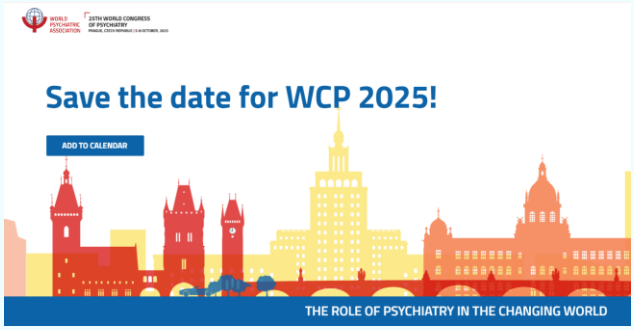
Future meetings

In this section you will find upcoming events in the field of Child and Adolescent Psychiatry. Click on the image and you will be redirected to the event website.

And please, we would like to invite you to help us build this section by sharing events you know about. Click on the following link and send us the details of the events you would like to publicize here - https://forms.gle/FFe1M8qnkPubmwWU7



The 25th World Congress of Psychiatry 2024

American Academic of Child and Adolescent Psychiatry (AACAP) – Annual Meeting

The 21st International ESCAP Congress

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