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Welcome to JAACAP Connect!

What is JAACAP Connect?
All are invited! JAACAP Connect is an online companion to the Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP), the leading journal focused exclusively on psychiatric research and treatment of children and adolescents. A core mission of JAACAP Connect is to engage trainees and practitioners in the process of lifelong learning via readership, authorship, and publication experiences that emphasize translation of research findings into the clinical practice of child and adolescent psychiatry.

Why do we need JAACAP Connect?
The field of child and adolescent psychiatry is rapidly changing, and translation of scientific literature into clinical practice is a vital skillset that takes years to develop. JAACAP Connect engages clinicians in this process by offering brief articles based on trending observations by peers, and by facilitating development of lifelong learning skills via mentored authorship experiences.

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Flat-Out: It Has Been a Good Year

Andrés Martin, MD, MPH, Alyssa Murphy, MA

In his provocatively titled blockbuster *The World Is Flat: A Brief History of the Twenty-First Century*, Thomas Friedman tracks the seismic shifts in global markets and emphasizes the increasing blurriness of geographic boundaries. He examines how physical distance presents an increasingly shrinking barrier to migration, communication, and collaboration, erasing advantages among competing countries.

As markets go, so goes psychiatry: the late John (“Jack”) F. McDermott, Jr., MD, whose support helped develop JAACAP Connect, smoothed out some wrinkles on this metaphorical map by expanding child and adolescent psychiatry (CAP) training to Indonesia. Jack arrived early to an international CAP scene that has been blossoming of late. This year alone, “Partnering for the World’s Children,” the international initiative of AACAP Past President Paramjit Joshi, MD, accomplished several of its goals, including the Academy joining forces with its Spanish counterpart in a first-ever AACAP meeting held abroad (in San Sebastian) and the launch of an international membership option; the International Association of Child and Adolescent Psychiatry and Allied Professions (IACAPAP) holding its biannual meeting in Calgary; and electronic educational resources like the IACAPAP e-Textbook edited from Sydney by Joseph M. Rey, MD, PhD, and the Massive Online Open Courses (MOOCs) coordinated from Paris by Bruno Falissard, MD, PhD, reaching every corner of the globe. It has been a flat-out good year to be a part of the international kinship of child and adolescent mental health.

Earlier this year, Connect’s editorial board paid tribute to Jack. In this issue, we revisit his legacy with particular attention to his international efforts, which will be discussed in more detail at this year’s Annual Meeting in New York City by three of the authors featured in this issue: Norbert Skokauskas, MD, PhD, Anthony Guerrero, MD, and Tjhin Wiguna, PhD. They examine trends in spreading CAP training worldwide, and they note Jack’s early and visionary role in these endeavors.

Connect will also feature in an Annual Meeting event. If you are interested in learning about publishing as a medical professional, how to boost your writing portfolio, or have a topic you think could be a valuable addition to Connect, consider stopping by Workshop 29, where Connect editors Michelle S. Horner, DO, and Oliver M. Stroeh, MD, and other members of the editorial team will offer concrete guidance on getting started in writing. This publication is itself the starting place for many first-time authors, and we welcome reader proposals. The fourth article in this issue was in fact the result of successful “pitching” to the editors: that is, at Jack’s encouragement, Dorothy Chyung, MD, put forward an idea and an outline for an article that was then accepted (instructions and guidance for getting involved in Connect can be found on the previous page). Here at Connect, we are leveling the playing field by encouraging participation from first-time authors, perhaps providing more evidence of our ever-flattening world.

Four generations of psychiatry chairs at the University of Hawaii: Walter Char, seated (Section of Psychiatry Chair 1965-1970), Naleen Andrade (Chair 1995-2012), Jack McDermott (Founding Department Chair 1970-1995), Anthony P.S. Guerrero (Chair 2012-present). Reprinted with permission of Naleen Andrade.
References

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Disclosure: Dr. Martin has received grant or research support from the National Institute of Mental Health. He has received royalties from Wolters Kluwer.

Ms. Murphy is a stockholder of Amgen, Celgene Corp, Gilead, AbbVie, and Merck.

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Global Mental Health and Cultural Psychiatry

Dorothy Chyung, MD, John F. McDermott, Jr., MD, Michelle S. Horner, DO

It is estimated that at least ten percent of the world’s population has a mental illness, and the global economic costs are estimated at $2.5 trillion. Mental disorders account for 7.4% of the world’s burden of health and almost 25% of all years lived with disability. Despite the overwhelming impact to societies worldwide, many individuals have limited or no access to mental health services. Many child and adolescent psychiatrists feel compelled to help but become overwhelmed by obstacles and cultural differences. In this article, we review two sometimes-contrasting programs designed to overcome perceived obstacles in providing mental health treatment at the global level, namely, the global mental health movement and cultural psychiatry.

The Global Mental Health Movement

The idea of helping with medical care in other countries, particularly of lower socioeconomic status, has existed since at least colonial times. Initially popularized as “tropical medicine,” mental health was not a priority, and some even believed that people in these non-Western countries were not sophisticated or modernized enough to have mental illness. The reach of tropical medicine expanded, eventually rebranding as “international health,” in part to separate itself from its history of colonialism. In the 1980s, the World Health Organization (WHO) broadened the ethos to “global health,” with an increasing focus on social equity and the biological and economic aspects of health that transcend national boundaries. Over time, global mental health became a discrete movement, supported by promotion from the WHO and by The Lancet’s global health series in 2007. Today, the global mental health movement aligns itself with universality, equity, access to care, and health (rather than illness) and mental health (rather than psychiatric illness).

Politics, pop culture, and world economics have contributed to the advancement of global mental health.

Bemme and D’Souza write that global mental health has gained some of its power from the creation and use of Disability Adjusted Life Years (DALYs), a measure by which mental and neurological disorders have a relatively high burden, with a corresponding high economic burden. Furthermore, they suggest that global mental health gains authority by using the assumed universality of evidence-based medicine, as well as a moral imperative to help others in our globalized world. Whitley posits that the movement’s ascension also relates to the rising concern for non-communicable diseases and an ever-increasing capacity for global thinking in younger generations.

How Does Cultural Psychiatry Differ From Global Mental Health?

Cultural psychiatry differs in concept from global mental health, although there are overlapping goals. Cultural psychiatry became a formalized academic discipline in 1955 with the formation of the Division of Social and Transcultural Psychiatry at McGill University. Rather than a public health mission, cultural psychiatry is interested in anthropology and academic considerations of culture within psychiatry. Cultural psychiatry focuses on questions such as the relativity of psychiatric diagnoses, treatments, and priorities; the provision of culturally sensitive care at the population and individual level; and the relationship between psychiatry and social power dynamics. The inclusion of a cultural formulation in the DSM is intended for practitioners to consider the role of culture in their understanding and treatment of patients. Cultural psychiatry views psychiatry as a cultural institution. For example, cultural concepts of distress, such as ataque de nervios or koro, serve as evidence of both the limitations of psychiatry’s diagnostic categories and the role of culture in the expression of emotions. Notably, cultural psychiatry has included critiques of global mental health, as detailed below.
Global Mental Health and Cultural Psychiatry

Cultural Psychiatry's Perspective of Global Mental Health

Leaders in cultural psychiatry have voiced criticism of the global mental health movement. Kirmayer and Pedersen, in particular, have outlined multiple concerns.7 They believe that global mental health priorities for local communities are often set by outside, wealthier countries, thus limiting the local voice.7 Summerfield has referred to global mental health as “medical imperialism.”8,9 He questions the validity of DSM psychiatric diagnoses in other cultures, suggesting that we are medicalizing normal reactions to difficult living conditions and that ameliorating these living conditions would be more helpful than providing psychiatric treatment. There has also been concern that the strong advocacy of medication use is in part to benefit the pharmaceutical industry, and that collaborations between local and Western universities are primarily for the latter's prestige.4

Another critique of global mental health is the focus on “scaling up” existing evidence-based treatments, rather than emphasizing the need for tailoring standard interventions to each local scenario. One poignant example is the cessation of antipsychotics by patients in rural Ghana who acknowledged that the medications alleviated their hallucinations, but they felt too weak and, by extension, unhealthy.10 Evidence-based medicine is inherently biased, as many studies are completed in specific populations, often with limited considerations of culture. Furthermore, negative trials are sometimes left undisclosed, and less lucrative interventions not always studied. In addition, prioritizing scaling up may lead to the preferential use of interventions that are easier to scale, rather than the most appropriate for the local culture. For example, a current popular strategy is the integration of mental health into the existing healthcare system, but it is unclear if this is the best approach for all cultures, especially given the limitations to existing infrastructure of many countries’ primary health care systems.5

As such, there is criticism that global mental health principles use local community health workers as a resource primarily to deliver “western” psychiatric interventions without having their own voice.2 There may be some situations in which local healers, who may have deeper knowledge of local social dynamics, may be able to better address a local mental health crisis. The balance of power between global mental health and local healers has been critiqued as a major shortcoming.2

Some suggest that global mental health allying with biology increases the credibility and general reception of mental illness.11,12 However, a consequence of global mental health aligning with biology is that it prioritizes the individual and limits the social.12 Global mental health believes that social injustice is related to disruptions in mental health, but the movement has been critiqued for prioritizing treatment based on the prevalence and economic burden of mental illness, whereas it may be more important to focus on social determinants of health, such as social inequality and unemployment.11 Global mental health’s focus on scaling up interventions has been criticized for making it easier to avoid more complex psychosocial solutions, i.e. a biomedical public health approach may draw attention away from social and structural determinants of health, as well as from more socially and culturally informed community-based strategies. Kirmayer and Pedersen point out potential consequences of the global mental health approach, including inappropriate diagnoses and interventions, missing social problems, undermining local knowledge, increasing stigma, and poorer health outcomes.7

Global Mental Health’s Response to Critiques

Patel, one of the key champions of global mental health, addressed some of cultural psychiatry’s critiques.13 First, the priorities of global mental health are based on the burden of disease. To some extent, it can be difficult to determine disease versus a normal range of human suffering within a local culture, in part due to a lack of the objective measures more commonly found in other fields of medicine. Nonetheless, there is strong research support for psychiatric diagnoses using standardized measures, regardless of the availability of universally accepted biomarkers. In addition, most research funding has come from governmental sources, and notably the pharmaceutical choices tend to be generic, thus limiting
the assertion that the global mental health movement is advancing the pharmaceutical industry.

Advocates for the global mental health movement feel the approach is culturally sensitive; for example, they will work with community-based organizations and have performed substantial research to ensure that interventions are adapted to the context. Miller, meanwhile, criticizes cultural psychiatry, suggesting that those in western countries put too much emphasis on preserving other cultures rather than allowing them to change and seem unwilling to criticize or test traditional healers’ methods.14 Bemme and D’Souza point out that there is some circular reasoning in the critique that global mental health does not pay attention to “culture,” in that simply by being global, it cannot then be local or cultural.2

**Future Directions for Global Mental Health**

Many of the suggestions for global mental health to become more culturally sensitive include greater involvement of local communities and stepping back by mental health professionals in other nations. For example, Campbell and Burgess propose a model in which communities take the lead in addressing mental health needs by being given the knowledge to recognize illness and how to access services but leaving it up to them to implement services.11 Support would be available but optional, and locals could create a safe space in which to have a dialogue about mental health and its treatment within their community. Another example comes from Gureje et al., who advocate for the use of traditional healers who can be trained in psychiatry or have the option of making referrals, allowing patients to choose their preferred type of treatment.15

Future considerations in global mental health include considering how to increase the overall validity of psychiatric diagnoses to improve applicability across cultures. For example, DeJong advocates for a new diagnostic system, either using a dimensional or network approach that would better address the question of the universality of existing psychiatric diagnoses.5 He also suggests that more research should be done on the efficacy of traditional healers. Sonuga-Barke recommends increasing research capacity in other countries and encourages researchers to take a more self-reflective stance on the influence of personal values and culture on their research.16

**Toward a Solution**

Ultimately, the controversy between cultural psychiatry and global mental health has fostered thoughtful discussion towards a common goal. All parties agree that addressing the social determinants of health is critical, although the extent and methodology is less clear. On the one hand, by virtue of global mental health’s focus on the global, there is a space to advocate for changing “social stressors” rather than just providing treatment. On the other hand, greater involvement in government and international markets might threaten other countries’ autonomy. Ongoing discussion and research will help delineate the boundaries and purview of global mental health. For example, a comprehensive approach to alleviate mental distress could address multiple levels of etiologies and solutions, including conflict resolution, poverty alleviation, social inequality, psychiatric interventions, traditional healers, etc. Through ongoing discussion and blending of initiatives, the ultimate goal of improving mental health worldwide can be achieved.

**What Does This Mean for Child Psychiatrists in the United States?**

In an increasingly globalized world, it is important to understand how our field is being practiced and disseminated. The debate between cultural psychiatry and global mental health is important to understand because the challenges of implementing western-based diagnoses may help us better understand the etiology, and thus treatment, of mental illness. Both cultural psychiatry and global mental health remind us to listen to patients and focus on their goals, which may or may not prioritize symptom reduction. We should strive to better engage our patients and communities in discussions about culture and mental health and treatment. We should advocate for the social determinants of health in our patients, rather than accepting the limitations of the status quo. We should consider the political, pharmaceutical, economical, and institutional influences on
diagnosis and treatment. We might question our field, including the limits and biases within research and diagnoses. We must challenge ourselves: the next time you see a patient, an interesting exercise might be to pretend as if you are in another country and consider how you might do things differently. We suspect the result would be to take a more critical stance of our work and further engage the patient and his or her community.

**Take Home Summary**

Cultural psychiatry and global mental health movements both advocate for improvement in mental health worldwide. Collaborative efforts are ongoing to increase access to services for our most vulnerable patients: children and adolescents.

**References**


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**Dorothy Chyung, MD**, is currently a clinical instructor and second year fellow in the Department of Child and Adolescent Psychiatry at New York University/Bellevue Hospital. She has a longstanding interest in anthropology and global health and is looking forward to her elective in Ghana this fall.

**John F. McDermott, Jr., MD** (deceased) was editor emeritus of the *Journal of the American Academy of Child and Adolescent Psychiatry*.

**Michelle S. Horner, DO**, is the editor-in-chief of *JAACAP Connect*. She is an assistant professor of psychiatry and behavioral sciences at Johns Hopkins Medicine.

**Disclosure**: Dr. Chyung reports no biomedical financial interests or potential conflicts of interest.

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Visit www.aacap.org/AnnualMeeting/2017 for the latest information!
Global Child and Adolescent Psychiatry: Challenges and Opportunities in a Flattening World

Norbert Skokauskas, MD, PhD, Anthony P.S. Guerrero, MD, Gordana Milavic, MD, FRCPsych, Bennett L. Leventhal, MD

In the December 2012 edition of *World Child and Adolescent Psychiatry (World CAP)*, the e-journal of the World Psychiatric Association, Child and Adolescent Psychiatry Section (WPA-CAP), the late John (“Jack”) F. McDermott, MD, who once chaired the section, concluded in an interview that “[a]s the world is flattening out, we are likely to see... a child and adolescent psychiatry... that becomes more globally encompassing in diagnosis as well as treatment....”1 This article aims to promote his vision of global youth mental health through a review of current WPA-CAP section activities.

Mental health is an essential part of child and adolescent health and wellbeing. Children and adolescents constitute a special population that is particularly vulnerable to the effects of adversity and disaster, as well as social and economic upheaval. According to the World Health Organization, at any one time, 10-20% of youth experience mental health disorders. More striking is the increasing awareness that at least 75% of mental health disorders begin in childhood and adolescence. And there is some evidence that the prevalence of neurodevelopmental disorders is increasing (whether or not this also reflects increased incidence is unclear).2

Based on the foregoing, it is evident that there is a growing need for CAP services in both the developed and developing regions of the world. Without more skilled professionals, we are facing a public health crisis of major proportions; this is a crisis that if left unattended could have a profoundly negative impact on all of the health care needs of our youth.

In 1977, the World Health Organization recommended that every country throughout the world have a national plan for child mental health. The United Nations Convention on the Rights of the Child (1989) was the basis of a 1990 international law codifying the basic protections that should be accorded to children. Similarly, the 1961 European Social Charter secured the rights of children. The Charter’s 1996 revision was expanded to include a list of core obligations among the signers, relating to the recognition of social, legal, and economic rights for children and young persons. These three international policies served as a stimulus for governments worldwide to develop national child and adolescent mental health policies and legislation.3

Despite the general consensus about the importance of youth mental health, and the policies and laws requiring that services be available, the scarcity of such services for children and adolescents remains worldwide, with evident detriments to children today and the adults that they will become in the future. It is not entirely clear how many child and adolescent psychiatrists there are in the world. In some sense, this lack of clarity reflects part of the problem.

With growing urbanization and industrialization, the demands on children and adolescents are increasing. There is a growing need for education and more sophisticated levels of adaptation in order to succeed in our ever more challenging world. And there are still far too many places where children face poverty, inadequate sanitation, limited health care and poor nutrition, as well as high levels of stress and exposure to violence and trauma; the latter two seem to be painfully common in even the most developed countries.4

Thousands of children and adolescent refugees are currently entering Europe. In 2015 there was a tenfold increase in the absolute number of unaccompanied minors in Germany and some other European Union (EU) countries.5 In the EU-28, 26% of all asylum applicants in 2014 were minors (19% < age 14; 7% between 14 and 17.9 years). They are exposed to many risks...
pre-flight, during their flight, and upon arrival; each stage can make these youth even more vulnerable to the risk factors that can then lead to the development of psychiatric illness.

Taken together, all of these factors serve to create or further complicate child and adolescent psychiatric disorders, which are among the most prevalent conditions facing today’s youth as they struggle to successfully make the challenging journey to adulthood. Clearly, there is a great and growing need for child and adolescent psychiatrists, especially those who can apply traditional approaches to diagnosis and treatment in multiple cultural contexts and towards a growing level of complexity of problems. Sadly, these needs have been anticipated for more than a quarter century. Although CAP is a recognized specialty in much of North America and Europe, that is not the case throughout the world. Postgraduate CAP training, where it exists, is distinct and systematized and produces a workforce that can meet at least some of the health care needs of our youth. However, workforce distribution is such that there is often an uneven distribution of specialists and a subsequent shortage in rural areas.

Over the past few years, WPA CAP has developed a much more engaged membership and has become more active in terms of its interest in the health of children and adolescents as well as in the broader interests of the field. World CAP is a freely accessible forum to share information about contemporary challenges and potential solutions throughout the globe. Through participation in conferences, visiting professorships, and other networking opportunities, WPA CAP members have fostered collaboration among child and adolescent psychiatrists seeking to expand services and to start programs aimed at growing or building skills in the workforce.

In order to extend our reach and provide evidence-based CAP services, it is imperative that we establish and maintain effective communication with our colleagues within our own and in related disciplines. By working closely with pediatricians, family physicians, psychologists, nurses, and other professionals, we can use our knowledge and skills to support their efforts, while teaching them how to optimize utilization of our services. Collaboration and co-location of services (either in person or virtually) will not only help patients but will imprint our role on the overall health care system.

The world calls each of us to learn a lesson or two from Dr. McDermott, who in the course of his education and career moved from the East Coast to Michigan and then to Hawaii, where he established strong programs focused on cross-cultural and indigenous child and adolescent mental health and collaborated both in person and remotely to establish CAP in the large and diverse nation of Indonesia. In thoroughly embracing and learning about diversity locally and in reaching out to the rest of the world, he advanced the science of our specialty and gave us both the inspiration and a concrete model to apply to make ourselves more globally relevant and accessible.

**Take Home Summary**

Only a small proportion of children needing health and mental health care ever receive them. The new challenges (including refugee and economic crises) put existing child and adolescent mental health services under even greater pressure and highlight the need for better services: more professionals and closer collaboration to address the mental health needs of children and adolescents worldwide.

**References**


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Dr. Guerrero reports no biomedical financial interests or potential conflicts of interest.

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Dr. Leventhal has served on the advisory board of the Brain Research Foundation. He has served as a consultant to Illinois Children’s Healthcare Foundation, and Janssen Research and Development, LLC. He has received grant support from the National Institutes of Health.

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Are you an early career child and adolescent psychiatrist interested in joining the JAACAP Connect editorial team?

Applications are currently being accepted for the 2018-2019 John F. McDermott Assistant Editor-in-Residence.

Interested applicants should contact support@jaacap.org.

Application deadline: February 15, 2017
What is the American Association of Child and Adolescent Psychiatry, and how does it differ from the Academy?

The American Association of Child and Adolescent Psychiatry was formed in 2013 as an affiliated organization of the Academy as a way for CAPs to increase their advocacy activities. Activities such as AACAP’s Legislative Conference, federal lobbying, grassroots, and state advocacy are all under the umbrella of the Association. It also allows for the existence of AACAP-PAC, but no dues dollars fund our PAC.

The mission of the Association is to engage in health policy and advocacy activities to promote mentally healthy children, adolescents, and families and the profession of child and adolescent psychiatry.

How does the Association affect me as a dues paying Academy Member?

Your dues remain the same whether you choose to be an Association member or not. On your yearly dues statement, you have the option to opt out of the Association. If you opt out and choose not to be an Association member, a portion of your dues will no longer go towards our advocacy efforts. Regardless, your dues will be the same, but you will miss out on crucial advocacy alerts, toolkits, and activities.

For any further questions, please contact the Government Affairs team at govaffairs@aacap.org.
Flavors From the Stewpot: Scholarship, Research, and Career Development in Hawaii

Deborah Goebert, DrPH, Anthony P.S. Guerrero, MD, Earl S. Hishinuma, PhD

ulu no ka lala I ke kumu (The reach of a tree’s branches depends on its trunk): this ‘ōlelo no‘eau, or proverb, may also metaphorically reference the role of predecessors in our strength and direction. Connections to our predecessors and place continue to be of cultural significance in Hawaii. They remind us that we have a role and responsibility to those who came before us, to our community, and to future generations. These bonds of interconnectedness define the relations important for wellbeing and growth. We need to recognize the holistic aspects of this knowledge, promote pursuit of knowledge, understand diversities of our connections, and apply these elements in practical ways. This framework enables us to provide service and support to the communities in Hawaii, as well as extend this knowledge outward from academia and in conjunction with the community, into the Pacific, throughout the world, and among underserved populations. It takes a visionary with a nurturing heart and a brilliant mind to initiate the scholarship, research, and career development programs that are optimally positioned to address these important challenges facing psychiatry. It is within this context that we celebrate the many contributions of Dr. John (“Jack”) F. McDermott, Jr., to our department and our field.

Scholarship Based on the Stewpot

People and Cultures of Hawai‘i was first published in 1974, and then again in 1980, as a text to educate mental health workers about the multiple ethnic groups in Hawaii.2,3 Notably, this first contribution was released nearly two decades before such concepts were included in the DSM.4 Culture is a filter through which people process their experiences and events of their lives. It influences people’s values, actions, and expectations of themselves as well as people’s perceptions and expectations of others. As a state where no ethnic group is a majority, Hawaii has often been referred to as a “melting pot.” The melting pot analogy can also be considered cultural assimilation—the process whereby a minority group gradually adopts the customs and attitudes of the dominant culture.

Dr. McDermott saw something different from a homogenizing “melting pot” and believed that Hawaii represented a distinctly positive exemplar of many ethnicities coexisting in harmony. Multiculturalism is a system of beliefs and behaviors that recognizes and respects the presence of all diverse groups in an organization or society, acknowledges and values their sociocultural differences, and encourages and enables their continued contribution within an inclusive cultural context that empowers all within the organization or society. In 2011, Drs. McDermott and Andrade used the “stewpot” model as an organizing theme for their edited book, People and Cultures of Hawai‘i: The Evolution of Culture and Ethnicity, wherein each ethnicity is a unique ingredient covered by a unifying sauce.5 This iteration built upon the previous versions to expand our understanding of the contributions of culture to the mental health of the people of Hawaii.

This perspective aided in developing culturally tailored intervention programs such as the Hawaiian Cultural Values Program for Hospitalized Youth,6 which promotes positive cultural identification as well as multicultural sensitivity.

Research

Not surprisingly, our departmental research has focused on health disparities. The vast majority of our departmental research was initiated and/or inspired by Dr. McDermott, including: findings of the National Center for Indigenous Hawaiian Behavioral Health, the Asian/Pacific Islander Youth Violence Prevention Center, and
Hawaii’s Caring Communities Initiative for Youth Suicide Prevention. A critical synthesis of previous research indicates that the pioneering work from the department’s first major grant has supported, directly or indirectly, more than 100 peer-reviewed journal articles. These included the first articles to research mental illness among Native Hawaiian and Filipino youth in Hawaii, as well as the potential mechanisms (particularly related to cultural identification and cultural conflict) for these disparities.

For example, Andrade et al. (2006) reported significantly higher rates (32.7%) of psychiatric diagnoses (particularly anxiety disorders) among Native Hawaiian youth. These rates were comparable to high-risk adolescent prevalence rates in other studies and nearly three times higher than the community youth prevalence rate. Yuen et al. (2000) demonstrated that Native Hawaiian adolescents had significantly higher rates of suicide attempts (12.9%) compared to other adolescents (9.6%) and that Hawaiian cultural affiliation (rather than ethnicity)—in addition to low socioeconomic status (SES), depression, and substance abuse—was a marker for suicide attempts. However, Goebert et al. (2000) found family support to be a strong protective factor for Hawaiian youth, especially regarding internalizing symptoms. Using data from a different local project, Guerrero et al. (2009) found that among Filipino youth in Hawaii, Filipino cultural identification appeared to be a protective factor against poor school performance and behavioral and emotional difficulties. Viewed collectively, these studies indicate that there is a need to better understand the dynamics of cultural adaptation in optimizing prevention and care for indigenous/colonized youth and youth from voluntary immigrant backgrounds.

Supporting Dr. McDermott’s vision, these studies have improved prevention and care for at-risk youth in Hawaii; furthermore, these research programs have launched the careers of faculty from under-represented minority backgrounds who have furthered Dr. McDermott’s legacy.

**Career Development**

Child and adolescent psychiatric services are in critically short supply in Hawaii, as they are throughout the world. In 1969, Dr. McDermott was recruited to help reorganize psychiatry into a department in the medical school and develop what would become a four-year accredited residency program. He also founded the child and adolescent psychiatry fellowship program and chaired the Department of Psychiatry from 1969 to 1995. Dr. McDermott was tirelessly committed to growing the workforce and improving diversity in our specialty. These goals were optimally accomplished through his dedication to recruitment, mentorship, and advancement of psychiatric and mental health research careers for indigenous people and immigrants in Hawaii.

The Department of Psychiatry has the distinction of having one of the highest rates of promotions/tenures out of all of the clinical departments in our medical school—a reflection of quality mentorship. Many of his mentees have gone on to serve as leaders in psychiatry locally, nationally, and internationally. Additionally, two of his mentees, Drs. Andrade (former chair) and Guerrero (present chair), have been inducted as fellows in the American College of Psychiatrists. But mentorship cannot be measured by such metrics alone. Like a good stew, it starts with a family recipe, flavored by each of the ingredients, then slow-cooked to allow the essence of each to be enhanced, and finally seasoned by understanding, strength, and experience to allow chances to be taken to improve the taste.

**Take Home Summary**

- Make time to develop close bonds with mentors.
- Take intellectual risks based on solid foundations.
References


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The Grandfather’s Legacy: Child and Adolescent Psychiatry Workforce and Research in Indonesia

Tjhin Wiguna, PhD, Raden Irawati Ismail, PhD, Noorhana Setiawati Winarsih, MD, Fransiska Kaligis, MD, Jan Prasetyo, MD

In his personal statement accepting the Jeanne Spurlock Lecture and Award for Diversity and Culture, published in the 2008 AACAP Honors Book, Dr. John (“Jack”) F. McDermott, Jr., stated that “the international work of which I am most proud was the establishment of our specialty in Indonesia, the fourth largest country in the world... They tell me I am not the father, but the ‘grandfather’ of child and adolescent psychiatry there.”1(pp6-7) This paper reviews the long-term impact that vision, mentorship, and collaboration can have on a large population with significant needs for child and adolescent psychiatric care. It includes personal reflections on mentorship and collaboration from the lead author and three co-authors, who were among Dr. McDermott’s original fellows.

Legacy is defined as something handed down from one generation to the next. Legacy comes from the Latin verb legare, meaning to appoint by a last will or send as an ambassador. Although Jack has already left us, the impact of his work still remains, and he will always be remembered. Child and adolescent psychiatry and the mental health workforce in Indonesia could not have been developed without Dr. McDermott’s helping hand. He was first introduced to the Department of Psychiatry, Universitas Indonesia by Prof. Kusumanto Setyonegoro in the early 1970s. During the period of 1961–1971, Prof. Setyonegoro, who was head of the Department of Psychiatry, founded many initiatives, especially educational programs.2 He developed a structured curriculum for psychiatry residency training and sent medical staff to study abroad. Some of the medical staff were sent to the Department of Psychiatry at the University of Hawaii John A. Burns School of Medicine, where Jack was in the early part of his 26-year-long career (1969–1995) as department chair.

The Grandfather's Legacy: The Past Collaboration

Prof. Edith Humries Pleyte, Dr. Jan Prasetyo, Dr. Melly Bhudiman, Dr. Lukas Mangindaan (deceased), and Dr. Betty Hardjawana (deceased) were the nation’s first child and adolescent psychiatrists who obtained fellowship training in the specialty at the University of Hawaii Department of Psychiatry. They spent approximately one year in Honolulu and had a chance to learn from and know Jack. Social gatherings and dinner at faculty members’ homes (including those of Jack McDermott, Tom Maretzki, Walter Char, William Bolman, and Dan Ponce) were memorable. Since then, the relationship grew, and Jack and several other colleagues from the University of Hawaii’s Department of Psychiatry came to visit Jakarta several times. They shared their wisdom and observed the works of their first pioneers as they returned to Jakarta and developed the child and adolescent psychiatry service at Dr. Cipto Mangunkusumo National Referral Hospital.

In 1976, the Hawaii-trained protégés began the first Indonesian child and adolescent psychiatry fellowship program, still using the curriculum from the University of Hawaii’s Department of Psychiatry, but adapted for a two-year instead of a one-year program. The program was hospital-based, and the graduating fellows received a certificate from the Department of Psychiatry Dr. Cipto Mangunkusumo National Referral Hospital. This was the one and only child and adolescent psychiatry fellowship program in the nation until 2014.

The fellowship program was evaluated several times during the period of 1997–2016, and the curriculum was also modified as needed. Around 2000, the program became more structured but consistently used the
University of Hawaii Department of Psychiatry’s format as its main template. Nowadays, with its newly developed curriculum, this program has been approved as a subspecialty in psychiatry with a concentration in child and adolescent psychiatry by the Faculty of Medicine Universitas Indonesia. Graduates receive a certificate from the Faculty of Medicine Universitas Indonesia and acknowledged by the Indonesian College of Psychiatry.

This subspecialty training began first at the Department of Psychiatry, Faculty of Medicine Universitas Indonesia. However, in 2014, the Department of Psychiatry at the University of Airlangga (Surabaya, East Java) implemented child and adolescent psychiatry training as a subspecialty. The training supervisors were originally trained at the department. The Indonesia College of Psychiatry has also acknowledged this second subspecialty training program and willingly accepts its graduates as child and adolescent psychiatry consultants. One of the pioneering Indonesian child and adolescent psychiatrists laid the groundwork for the fellowship and subspecialty training and built the child and adolescent mental health services. Jack and other colleagues from the University of Hawaii Department of Psychiatry supportively watched from far away.

**The Grandfather’s Legacy: The Present Collaboration**

After the pioneers set up the fellowship in the Department of Psychiatry at Universitas Indonesia and trained child and adolescent psychiatric subspecialists, the number of child and adolescent psychiatrists grew from the original 5 in 1976 to its current number of around 50, half of whom are in Jakarta. This number is still not enough for the whole nation, with its current population of almost 250 million people spread throughout an 18,000-island archipelago that spans over 3,000 miles from east to west. Much more work needs to be done, and the collaboration needs to be continued.

Based on discussions involving Jack McDermott, Anthony P.S. Guerrero (University of Hawaii Department of Psychiatry), Tjhin Wiguna, (Department of Psychiatry Universitas Indonesia), Ika Widyawati (Department of Psychiatry Universitas Indonesia), and Melly Budhiman (Indonesian Autism Foundation) at the 56th AACAP Annual Meeting in Honolulu, Hawaii in 2009, the collaboration continued to the next level.

The Indonesian child and adolescent psychiatry workforce has since then become much more focused on research, scientific publishing, and collaborative education via video teleconferencing (VTC). The memorandum of understanding (MoU) between the Department of Psychiatry at Universitas Indonesia and the University of Hawaii Department of Psychiatry was executed in 2014. Several collaborative scientific papers have been published in areas as diverse as neuroimaging and cross-cultural psychiatry with a focus on the Asia-Pacific region (Table 1). VTC forums have allowed for mutual sharing of experiences and education (seminars, journal clubs) on various child and adolescent psychiatric topics, ranging from biological to psychosocial and cultural issues.

**Conclusion**

As posted in the Honolulu Star-Advertiser Obituaries, Jack McDermott’s founding of the Indonesia–Hawaii collaboration. He always held Indonesia close to his great heart, and he continued to support child and adolescent psychiatry development in Indonesia throughout his entire career. All of us are forever grateful.
Take Home Summary

The collaboration between the Department of Psychiatry Dr. Cipto Mangunkusumo National Referral Hospital—Faculty of Medicine Universitas Indonesia and the Department of Psychiatry of the University of Hawaii that has lasted several decades strengthens the child and adolescent psychiatry educational programs in Indonesia. In addition, the use of new technologies such as VTC makes the program more advanced in communicating and discussion without any need to leave the country. The knowledge and experience that we discussed and shared from the VTC of the present collaboration were disseminated to our residents and fellows, and applied in the clinical and community child mental health workforces.

Table 1. Published Scientific Papers From the Collaboration Between the Department of Psychiatry Dr. Cipto Mangunkusumo National Referral Hospital—Faculty of Medicine Universitas Indonesia and University of Hawaii Department of Psychiatry, John A. Burns School of Medicine

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<thead>
<tr>
<th>No.</th>
<th>Title</th>
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<tr>
<td>1.</td>
<td>Psychiatric Morbidity Among Children in North Aceh District (Indonesia) Exposed to the 26 December 2004 Tsunami</td>
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<td>2.</td>
<td>Effect of 12-Week Administration of 20-mg Long-Acting Methylphenidate on Glu/Cr, NAA/Cr, Cho/Cr and ml/Cr ratios in the Prefrontal Cortices of School-Age Children in Indonesia</td>
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<td>3.</td>
<td>Care for the Seafarers: A Review of Mental Health in Austronesia</td>
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<td>4.</td>
<td>The University of Hawai‘i/University of Indonesia Collaboration to Build and Sustain a Child Psychiatric Workforce</td>
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<td>5.</td>
<td>The Amygdala’s Neurochemical Ratios After 12-Weeks Administration of 20 mg Long-Acting Methylphenidate in Children With Attention Deficit and Hyperactivity Disorder: A Pilot Study Using 1H Magnetic Resonance Imaging</td>
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<tr>
<td>6.</td>
<td>Executive Dysfunction Among Children With Antipsychotic Treated Schizophrenia</td>
</tr>
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Published in:
1. Asia-Pacific Psychiatry, 2010
3. Asia-Pacific Psychiatry, 2013
5. Clinical Psychopharmacology and Neuroscience, 2014
6. Clinical Psychopharmacology and Neuroscience, 2014

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**JAACAP October Issue - Available Now!**

Even for a city that is constantly changing, the New York skyline visible from the Brooklyn Bridge is remarkably different from the last time AACAP’s Annual Meeting rolled into town, in 2010, due in no small part to the addition of the massive One World Trade Center building. AACAP itself is not the same organization that convened in Manhattan six years ago. Our membership continues to grow, innovative projects provide new opportunities for members to be involved and develop new skills, and even familiar programs and products like the Annual Meeting and JAACAP have evolved over time to fulfill the needs of child and adolescent psychiatrists around the world. We are, like our host city, in a state of continual metamorphosis.
JAACAP Connect is interested in any topic relevant to pediatric mental health that bridges scientific findings with clinical reality. As evidenced by our previous editions, the topic and format can vary widely, from neuroscience to teen music choices. What trends have you observed that deserve a closer look? Can you envision reframing key research findings into clinical care? Do you want to educate others on a broader scale, thereby improving the health of children around the country, the world? We encourage all levels of practitioners and researchers, from students to attendings, to join in and participate.

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