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EPIDEMIOLOGY AND PUBLIC HEALTH SECTION

Congress of the WPA Epidemiology and Public Health Section

MENTAL HEALTH IN AN INCREASINGLY POLARIZED AND
UNCERTAIN WORLD: THE ROLE OF EPIDEMIOLOGY AND
PUBLIC HEALTH



September 29 / October 2 **2026**

Cagliari, Sardinia, Italy
Hotel Regina Margherita

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ABSTRACT BOOK

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Welcome Letter

Dear Colleagues and Friends,

It is with great enthusiasm that I welcome you to our scientific society meeting in Italy, where we will gather to explore one of the most pressing challenges of our time: "Mental health in an increasingly polarized and uncertain world: the role of epidemiology and public health."

Mental health is a cornerstone human wellbeing, yet it remains profoundly vulnerable to the societal forces that shape our contemporary world. As we witness political polarization, economic inequality, and global uncertainty rise, we are simultaneously observing rising rates of psychiatric disorders and distress important population subgroups. Conflicts, forced migration, and climate-related disasters continue to test the resilience of communities worldwide. Never has our work been more vital, nor has the need for evidence-based public health approaches been more urgent.

Our meeting theme recognizes that mental health cannot be understood in isolation from the social, political, and economic contexts in which people live. The symposia we have assembled reflects this comprehensive approach, from examining how political violence and polarization contribute to psychiatric distress, to exploring trauma and forced migration's psychological toll, to advancing methodological innovations that will shape the future of our field. We will delve into critical human rights perspectives on mental healthcare quality, harness the potential of artificial intelligence and social media for surveillance and intervention, and trace mental health trajectories across the entire life course from adolescence to older age.

What makes our gathering particularly valuable is the opportunity for genuine scientific exchange across geographical, cultural, and disciplinary boundaries. In an era when isolation and division are ascendant, our international collaboration stands as a powerful counterforce. Sharing unique perspectives shaped by regional contexts, research traditions, and clinical experiences will galvanize collaboration and scientific advancements.

Italy provides an inspiring backdrop for our deliberations, with its rich history of pioneering community mental health reforms and commitment to human dignity in psychiatric care. As we convene in this setting, we honor both the progress achieved and acknowledge the considerable work that remains. Our discussions will not only advance scientific knowledge but also we hope can inform policies and interventions that can meaningfully improve lives across diverse populations.

I encourage you to engage fully in the formal sessions, informal discussions, and collaborative opportunities this meeting provides. Together, we can forge new pathways for understanding and addressing mental health in our complex world, translating epidemiological insights into actionable public health strategies.

Welcome to what promises to be an intellectually stimulating and impactful meeting.

With warm regards,

Katherine Keyes, Ph.D

President, WPA Epidemiology and Public Health Section

Organization & Committees

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Oral Presentations Session I

Thursday, October 1st, 2026

(OP 01 – OP 07)

A post pandemic recovery in young people's mental health

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Introduction: Few data exist on the patterns of young people's mental health after the pandemic which was widely claimed to lead to an exacerbation of the decade-long decline.

Method: We used data from 2 country-wide long term community studies to evaluate the recent trends in the mental of Australia's young people

(1) the mission Australia youth survey (n=c15,000 high school students/year from 2012-2025), using the % with K10 indicating high distress, and

(2) the Hilda panel survey (n=c13,000 people per year from 2001-2024) using the SF36 MHI-5 subscale comparing the trends in mental health symptoms in those aged 15-24 to older participants

Results: The mental health of high school students and young Australians has improved year on year since the end of the pandemic although the pattern differs slightly by data source/age group. The prevalence of high levels of psychological distress (and most of other wellbeing indicators) did not increase above the long-term trend during COVID and has now dropped back to that of over a decade ago (fig 1). Conversely the pre-pandemic decline in the mean population mental health of young adults did accelerate during 2020 and has not recovered to pre-2019 levels, but to the long-term trend (fig 2).

Conclusion: Despite the apparent worsening of some global mega-trends (conflict, cost of living) convergent population level data show a pattern of several years of improving mental health in young Australians, challenging some of the discourse around causes and ongoing youth mental health crisis.

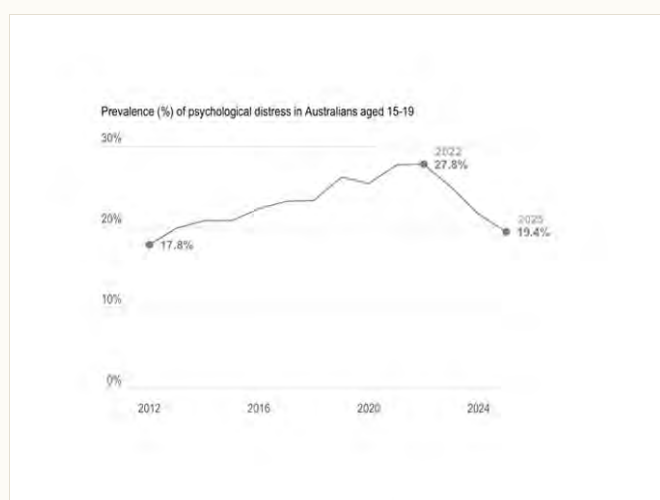


IMAGE 1

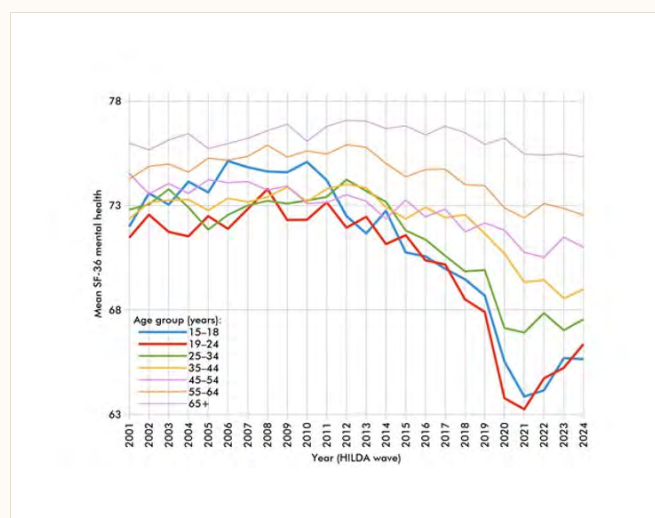


IMAGE 2

An interpretative phenomenological analysis of mental health and psychosocial support among faith-based actors in Northern Nigeria

Margaret Isioma Ojeahere^{1,2}, Sahmicit Kumswa³, Toluwalope Orotayo⁴, Innocent Isama⁵, Bisoye Lukman Towolawi⁶, Olusoji Victor Ladele⁷

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Introduction: In an increasingly polarized and uncertain world, Nigerian communities face worsening insecurity, economic hardship, and social fragmentation. Within this context, faith-based actors have become critical responders and are often the first point of contact for people experiencing mental health problems and their caregivers. Driven by cultural beliefs, mental health-related stigma, shortage of mental health professionals, unaffordability and inaccessibility of formal services. This study uses an interpretative phenomenological analysis (IPA) approach to explore how faith actors experience and interpret their roles in providing mental health and psychosocial support (MHPSS) in fragile communities, and how they use the experiential knowledge to support affected individuals and strengthen communities.

Method: In-depth interviews, focus group discussions, pathway mapping exercises were conducted with 28 purposively selected Christian and Muslim faith actors in northern Nigerian communities. Interviews were audio recorded, transcribed verbatim, and analysis followed an idiographic, interpretative process to understand how participants construct meaning around psychosocial distress, support practices, and their interactions with formal health systems.

Results: The study demonstrated six interconnected themes shaping how faith-based actors perceive and respond to mental health and psychosocial distress in northern Nigeria. Socioeconomic hardship was seen as a root cause, while security crises and conflicts compounded trauma. Substance use emerged as both coping and risk factor. Family rupture and weak spousal support worsened distress. Stigma limited access to formal care. Finally, systemic failures and coordination gaps amplified unmet psychosocial needs, underscoring reliance on faith-based actors as frontline providers.

Furthermore, lived experiences of participants revealed three distinct MHPSS pathways: A functional pathway, where faith actors felt confident offering support and facilitating successful referrals; A broken pathway, where attempted referrals collapsed due to stigma, mistrust, or weak system linkages; and a non-existent pathway, where no referral options were known or available, with harmful outcomes in several instances.

Conclusion: This study underscores the importance of faith-based experiential knowledge within public health systems and reveals the critical role and psychological burden that faith-based actors bear as frontline responders, highlighting the urgent need for system level reforms that strengthens their MHPSS capacity, promote mental health literacy, improve referral networks, and safeguard communities.

Mental health and psychosocial support among faith-based actors in Northern Nigeria



IMAGE 1 · MAP OF STAKEHOLDERS

Referral Pathway Status

MHPSS Pathways in Nigeria

Non-existent Pathways	Broken Pathways	Pathways That Work
<i>Referral channels that do not exist or are completely inaccessible</i>	<i>Referral channels that exist but are dysfunctional or inconsistently applied</i>	<i>Functional referral channels with demonstrated effectiveness</i>
<i>A youth seeks help from a faith leader, but there is no referral link to PHC or professional care/ support ends at prayer or counseling.</i>	<i>A faith leader refers someone to a health facility, but no feedback or follow up occurs, the person feels lost and disengages from care.</i>	<i>A faith leader identifies distress, provides initial support, and successfully refers the individual to a PHC worker who offers care and updates the faith leader ensuring continuity and trust.</i>

IMAGE 2 · REFERRAL PATHWAY STATUS

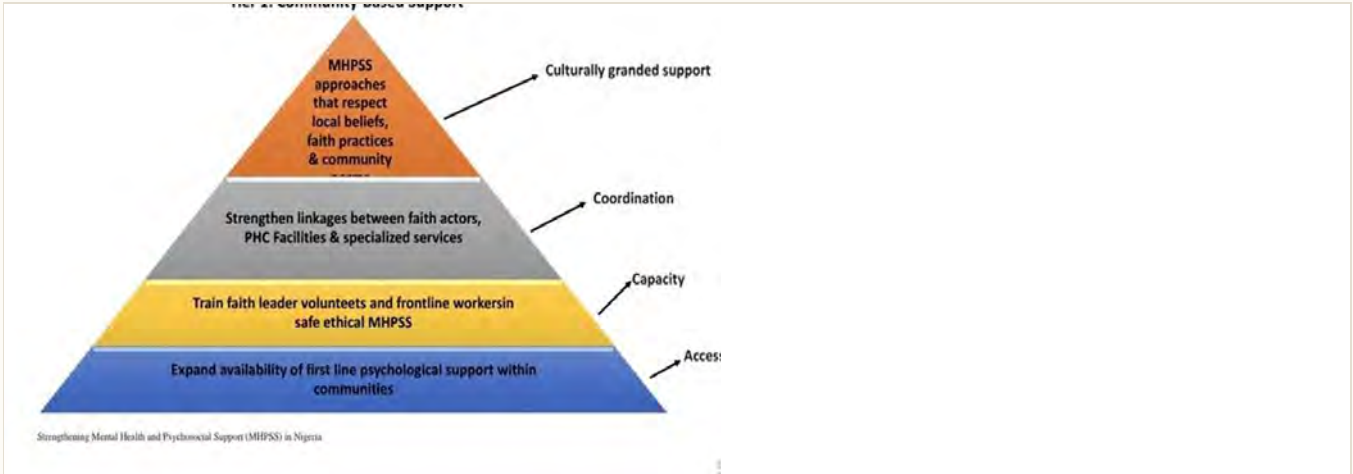


IMAGE 3 · TIER 1: COMMUNITY-BASED SUPPORT

Differences in perinatal mental health care utilization among migrant and Dutch-born women: A population-based retrospective cohort study

Caterina Ceccarelli^{1,2,3}, Cansu Alokkan Sever^{1,2,3}, Karen Holtmaat^{1,3}, Jens Henrichs^{3,4,5,6}, Chris van Klaveren^{1,3}, Maria Marti-Castaner⁵, Marit Sijbrandij^{1,2,3}, Anke B Witteveen^{1,2,3}

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Introduction: Migrant women in the perinatal period face high risk of mental disorders, with one in four experiencing depression and one in five anxiety disorders. Yet, even in high-income countries like the Netherlands, they encounter barriers to accessing care. This study examines differences in perinatal utilization of specialized mental health care between migrant and Dutch-born individuals in the Netherlands.

Method: This is a population-based retrospective cohort study based on Statistics Netherlands (CBS) microdata (2015–2018). The study included mothers of children born in the Netherlands who were residing in the country during the perinatal period. Cox proportional hazards regression estimated the association between migration status and time to specialized mental health care initiation by diagnoses.

Results: Data were available for 343,026 women, of whom 15% were migrants. Specialized care was utilized by 279.39 in 10,000 persons years among Dutch-born and 205.11 in 10,000 migrant women perinatally. Overall, migrants utilized specialized mental health care 39% less than Dutch-born individuals [adjusted hazard ratio (aHR) = 0.61, 95% CI (0.58–0.64)]. Utilization was significantly lower among migrants across all analyzed diagnostic categories (anxiety, depressive, bipolar and mood, substance use, personality, and other disorders), except schizophrenia and psychotic disorders, where utilization was non-significantly higher than in Dutch-born women. Subgroup analyses indicated lower utilization among women from conflict-affected countries, and among recent migrants.

Conclusions: Migrant women utilize specialized perinatal mental health care less frequently than Dutch-born women, with variations by migration characteristics. These findings underscore the need to strengthen the pathways to mental health care in this population.

Mental health of adolescents affected by the Russo-Ukrainian war: A time-trend study

Andre Sourander^{1,2,3}, Sanju Silwal^{1,2}, Minja Westerlund^{1,2}, Matthew Hodes⁴, Emmi Heinonen^{1,2}, Susanna Hinkka-Yli-Salomäki^{1,2}, Yuliia Yaschchyshyna⁵, Gennadiy Putyatin⁵, Norbert Skokauskas⁶, Olga Osokina^{1,5}

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Introduction: The Russo-Ukrainian war, which began in 2014 and escalated with the full-scale invasion in 2022 has posed significant mental health burden. However, evidence on the impact of the war on Ukrainian adolescent mental health across different phases of the war is limited. This study examines trends of wartime traumatic stressors and well-being of adolescents during different stages of the war.

Methods: This time-trend study uses repeated cross-sectional school-based surveys of adolescents aged 11-17 years conducted in 2016-17 (n = 2766) and 2023 (n = 2720). The 2016-17 was carried out in the Donetsk region, which had been affected by conflict since 2014 and the Kirovograd region, which had not been directly exposed to the war at that time. The survey was repeated in 2023, after the 2022 full-scale invasion in the same two regions using identical methodologies. Adolescents self-reported wartime traumatic stressors and mental health problems, bullying, loneliness, substance use, resilience and family functioning. In 2016-17, adolescents completed questionnaires in their classroom supervised, while in 2023, questionnaire were completed either on paper or online. Response rates across survey waves have ranged between 90.3%-98.5%. A new survey is planned for 2026-2027 in the same regions among the same age group (estimated sample size =3,000) using identical methodologies.

Results: Adolescents residing in Ukraine during the full-scale invasion experienced high levels of post-traumatic stress disorder (PTSD), depression, and suicidality. For example, suicide attempts in non-war areas were 3.8% and 6.8% in war-affected areas in 2016-17, while 11.7% in 2023 during the full-scale invasion. Exposure to multiple wartime traumatic stressors were associated with adverse mental health outcomes.

Conclusion: As the full-scale invasion enters its fifth year, these findings highlight the urgent need to scale up mental health interventions for youth affected by ongoing war. This study provides unique data on the mental health of war-exposed Ukrainian adolescents, which has been collected through all phases of the war from pre-full-scale war anxieties, to displacements, and war-related trauma. The 2026-2027 survey will further provide evidence on how the intensity and severity of war exposure influence adolescent well-being over time.

Stable social inequalities in suicidal ideation amid rising prevalence: Evidence from two Brazilian national health surveys (2013–2019)

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Introduction: The social patterning of mental health is well documented, but whether inequalities in suicidal ideation widen, narrow, or persist over time remains unclear, particularly in middle-income countries. In some high-income settings, subgroup trajectories have diverged across recent years. We asked whether the social distribution of suicidal ideation in Brazil shifted between 2013 and 2019, a period of rising overall burden, or whether risk gradients by sex, income, education, age, and region remained stable.

Method: We analysed adults aged ≥ 18 from the Brazilian National Health Survey (PNS) 2013 ($n \approx 60,191$) and 2019 ($n \approx 88,509$). Suicidal ideation was assessed with PHQ-9 item 9; depressive symptoms were measured continuously using PHQ-8 (items 1–8). We fitted a pooled, survey-weighted quasi-Poisson generalized linear model (svyglm) accounting for the complex sampling design, estimating prevalence ratios (PR). Year $\times$ covariate interaction terms tested whether each association changed between waves. Analyses used complete cases in R 4.5.2.

Results: Crude prevalence of suicidal ideation rose approximately 24% between waves. Despite this increase, the social gradient was largely stable: female sex ($PR \approx 1.23$), lower income, lower education, and depressive symptoms ($PR \approx 1.21$ per point) remained independently associated with higher prevalence, while age ≥ 70 stayed protective ($PR \approx 0.70$). The year's main effect was non-significant after adjustment. The main exception was geographic: three significant regional interactions showed the Southeast, South, and Central-West converging toward the historically higher prevalence of the North.

Conclusion: Brazil's social inequalities in suicidal ideation persisted between 2013 and 2019 even as overall prevalence rose – the same disadvantaged groups continued to bear a disproportionate burden. This stability, contrasting with the diverging subgroup trajectories reported in some high-income settings, is itself a substantive finding. Combined with regional convergence toward higher-risk levels, it argues for sustained, equity-oriented prevention rather than assuming the distribution of risk has shifted.

Trauma exposure and posttraumatic stress disorder among immigrant Canadians: Results from the survey on mental health and related events

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Introduction: Immigrants are commonly exposed to unique stressors and traumatic events before, during, and after migration to a new country, including racial discrimination among minority groups. Despite this, several epidemiologic studies have demonstrated a lower burden of mental disorders among immigrants in comparison to the general population, although mental healthcare utilization has consistently been lower. To date, however, differences between immigrants and non-immigrants with respect to a range of traumatic event exposures and PTSD have yet to be examined in Canada, particularly post-COVID in a contemporary, nationally representative sample.

Methods: The Survey on Mental Health and Stressful Events (2023; n=14,600) was a nationally representative survey of Canadian adults. Participants were asked whether they were an immigrant or non-permanent resident (yes/no) as well as how many years since becoming a permanent resident. A range of traumatic events was queried, and probable PTSD was assessed using the Posttraumatic Symptom Checklist (PCL-5). Regression analyses compared estimates between immigrants and Canadian-born participants with regards to PTSD and trauma exposures.

Results: Among immigrants, 52.7% reported exposure to one or more traumatic events, compared with 67.0% among non-immigrants. The prevalence of probable PTSD among immigrants was lower compared with those who were not immigrants (6.5% vs. 9.0%), as were mean levels of all PTSD symptom clusters (i.e., intrusions, avoidance, negative cognitions and mood, hyperarousal). A greater number of years since becoming a permanent resident was associated with higher odds of any trauma exposure, but lower odds of PTSD. Additional analyses will examine differences in exposure to specific traumatic events, as well as gender, race/ethnicity, and social support as moderators of PTSD and trauma exposure among immigrants.

Conclusion: Results will be discussed in the context of advocating for accessible and culturally informed trauma-focused treatments for Canadian immigrants.

Beyond “Hard to Reach”: Evidence from the ROSHNI-2 trial on culturally adapted maternal mental health interventions for British South Asian families

Farah Lunat^{1,2,3}, Nusrat Husain², Tanveer Ahmed⁴, Deepali Sharma³, Nadeem Gire³, Rakhshi Memon³

¹Lancashire And South Cumbria NHS FT Trust, Preston, United Kingdom, ²University of Manchester, United Kingdom, ³Manchester Global Foundation, London, United Kingdom, ⁴Shifa Surgery Ltd, Blackburn, United Kingdom

Introduction: Mental-health inequalities remain a pressing public-health challenge. British South Asian women experience up to three times higher rates of postnatal depression yet remain under-represented in research and services. The ROSHNI-2 trial tested the clinical and cost-effectiveness of a culturally adapted group cognitive-behavioural therapy intervention, the Positive Health Programme (PHP), delivered in community settings by trained female facilitators. This abstract synthesises the main clinical and economic outcomes to highlight implications for equitable service design and population-level mental-health policy. The word ROSHNI means light in Urdu/Hindi.

Method: ROSHNI-2 was a multicenter, randomized controlled trial recruiting over 4000 women and randomising 732 British South Asian women across five UK regions. Participants were randomized to PHP plus usual care or usual care alone. The intervention was delivered in six South Asian languages and incorporated family-inclusive consent, bilingual materials, and community-based venues. Outcomes included depressive-symptom reduction at 4 and 12 months and cost-effectiveness analysis from NHS and societal perspectives. Retention strategies included monthly contact, culturally sensitive follow-up procedures, and flexible scheduling to accommodate childcare and family commitments.

Results: Women receiving PHP showed significantly greater symptom reduction and earlier recovery at 4 months compared with usual care, with sustained improvements at 12 months. Engagement and retention exceeded 80 %, demonstrating feasibility in a population often labelled “hard to reach.” Economic evaluation confirmed PHP as cost-effective, with lower incremental cost per quality-adjusted life-year and reduced service-use costs. The model’s success was driven by culturally humble recruitment, language-matched delivery, and strong community partnership.

Conclusion: ROSHNI-2 provides robust evidence that culturally adapted, community embedded psychological interventions can achieve both clinical benefit and economic efficiency. In fragmented societies, the effectiveness of interventions depends on how well they include those most often overlooked. Embedding cultural humility, co-production, and family centered engagement into research and service design can transform access and outcomes for minoritized communities, strengthening mental health resilience and equity at population level.

Funding: National Institute for Health and Care Research (NIHR) HTA Programme [14/68/08]

ROSHNI-2 engagement strategies

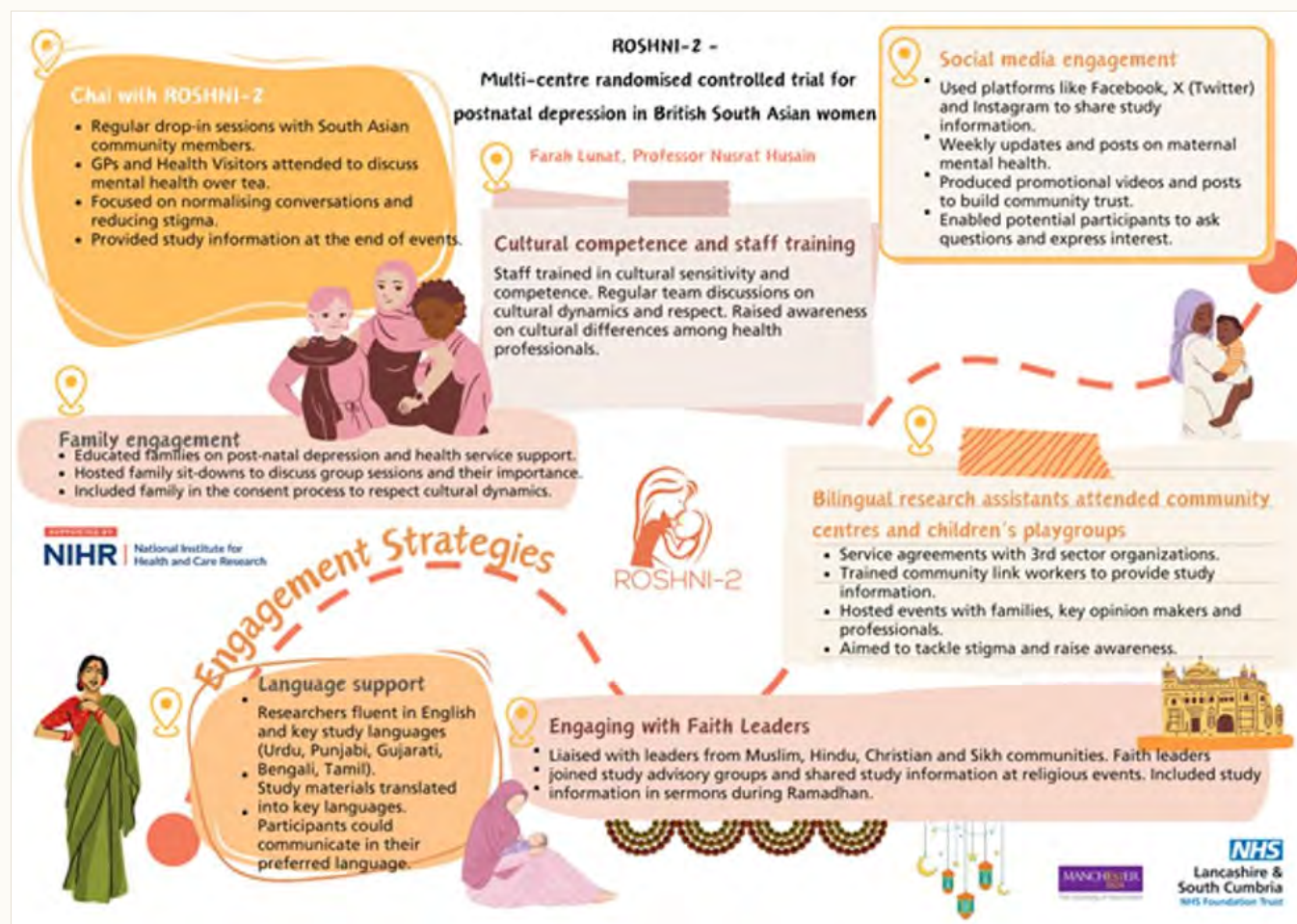


IMAGE 1 · ENGAGEMENT STRATEGIES

Oral Presentations Session 2

Thursday, October 1st, 2026

(OP 08 – OP 14)

Nationally representative surveys of experiences of discrimination and positive treatment in people with mental health problems in Australia: Changes over 10 years

Nicola Reavley¹, Anna Ross¹, Rachel Green², Gayle McNaught², Amy Morgan¹

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Introduction: Reducing stigma and discrimination has been a priority in many national mental health policies for decades. The aim of this study was to explore population-level changes in experiences of discrimination and positive treatment between 2014 and 2024.

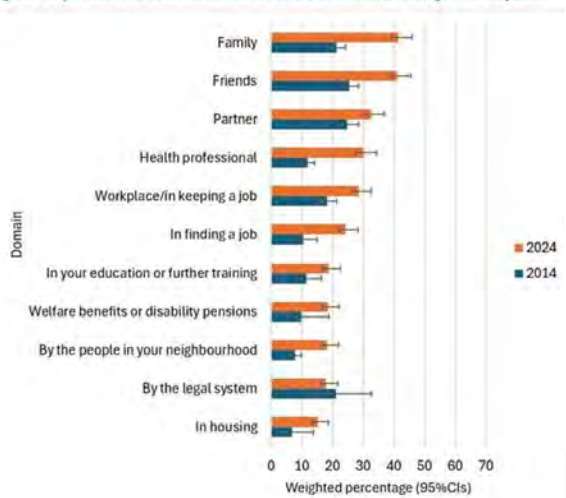
Methods: Large nationally representative surveys of Australian adults were conducted in 2014 and 2024. For each, those who reported a mental health problem or scored high on a screening questionnaire (n=1381 in 2014, n=2613 in 2024) were asked about experiences of discrimination and positive treatment in multiple settings. Regression analyses were used to explore whether changes between survey years were significant at $p < .01$, adjusting for sociodemographic variables of age, gender, education level, country of birth and type of mental health problem.

Results: In 2024, participants were more likely than in 2014 to report experiencing discrimination (OR=1.77 [99%CI 1.38,2.26], $p < 0.001$) and in family, friends, partners, health professionals, workplace and neighborhood settings. In 2024, any positive treatment was less common (OR=0.67 [99%CI 0.52,0.88], $p < 0.001$), but more common in friends, family, workplace and health professional settings. Increases in discrimination were generally greater than those for positive treatment, and were largest in family, neighborhood, finding work (and health professionals). Increases in discrimination were greater among women and among those reporting any anxiety disorder.

Conclusion: Study findings highlight the need for sustained and targeted efforts to tackle discrimination and improve support. Any interventions should be carefully developed and disseminated based on their ability to bring about tangible behavior change in their target audiences, without inadvertently heightening sensitivity to perceived threats.

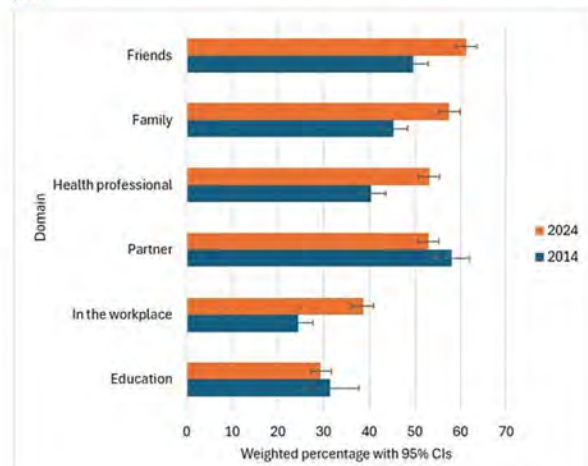
Discrimination and positive treatment: change over 10 years

Figure 1 Experiences of discrimination in different domains: change over 10 years



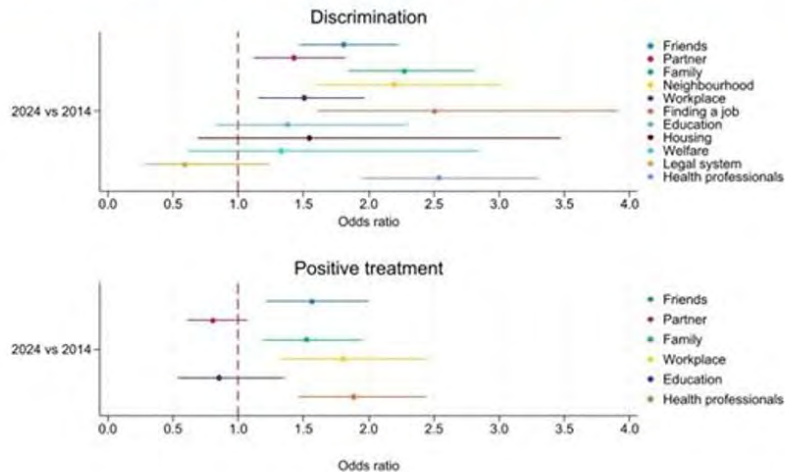
IMG 1 · DISCRIMINATION

Figure 2 Experiences of positive treatment in different domains: change over 10 years



IMG 2 · POSITIVE TREATMENT

Figure 3 Changes in experiences of discrimination and positive treatment in 2024 versus 2014, controlling for sociodemographic and mental health problem characteristics, with 99% confidence intervals



IMG 3 · 2024 VS 2014, ADJUSTED ODDS RATIOS

Recovery colleges: Evidence for an accessible innovation in mental health

Claire Henderson¹, Jason Grant-Rowles², Mike Slade³, Rachel Elliot⁴, Daniel Hayes⁵, Tesnime Jebara¹, Stella Lawrence², Vanessa Lawrence¹, Mariam Namasaba¹, Amy Ronaldson¹, Dora Shergold², Simran Takhi³

¹King's College London, London, United Kingdom, ²RECOLLECT Lived Experience Advisory Panel (LEAP), London, United Kingdom, ³University of Nottingham, United Kingdom, ⁴University of Manchester, United Kingdom, ⁵University College London, United Kingdom

Introduction: Emerging in England in 2010, Recovery Colleges apply principles of adult-education, co-learning, co-production, and equality between people with lived and professional experience, to promote recovery, wellbeing, and citizenship. They operate in over 31 countries across six continents.

Early evidence on Recovery Colleges showed promise but called for more rigorous national and international evaluation. This talk presents the main results of the RECOLLECT programme of research on the effectiveness, cost effectiveness and implementation of recovery colleges in England.

Method: RECOLLECT comprised i) a national survey of Recovery Colleges, ii) a prospective cohort study to establish the relationship between fidelity, mechanisms of action and psychosocial outcomes, iii) a prospective cohort study to investigate effectiveness and cost-effectiveness, iv) a retrospective cohort study to determine the relationship between Recovery College use and outcomes and mental health service use, and v) organisational case studies to establish the contextual and organisational factors influencing fidelity and outcomes. A Lived Experience Advisory Panel provided input into all stages of the research.

Results: We found 88 RCs in England in 2021, and 63 RC managers completed our survey. Most RCs showed good alignment with recovery principles.

Results from the prospective cohort study indicate benefits of enrolment sustained at 12 months follow up in relation to the primary outcome, quality of life, and most of the secondary outcomes measured. Relationships between fidelity and outcomes and effectiveness and cost-effectiveness compared to the control group at 4 months will also be presented.

The retrospective cohort study showed that one year after RC enrolment, students had larger reductions in mental health service use compared with non-students, saving the Trust over £5,000 per student. For every £1 invested in Recovery Colleges, services received £8.40 return due to reduced mental health service use.

Case studies show that RCs meet fidelity criteria through continuous, locally situated work. Consistent with the quantitative data, students reported reduced social isolation and feelings of empowerment, greater self-knowledge and self-efficacy, and a sense of liberation.

Conclusion: Our findings taken together suggest that enrolling at a Recovery College benefits the individual and saves services money.

Touching grass in a digital world: How SocialVoice reimagines participatory mixed methods to maximize impact of social media and mental health research

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Introduction: To support participatory research about social media and mental health, we co-designed Grounded Socials-Visualization using SocialVoice with community stakeholders—an adaptation of grounded visualization from Photovoice to newly integrate participant-donated social media, qualitative participatory insights and quantitative survey results. Prior studies have excluded qualitative and social media narratives from youth and instead relied on simple survey or smartphone data, limiting trust, power-sharing, impact, and meta-inference.

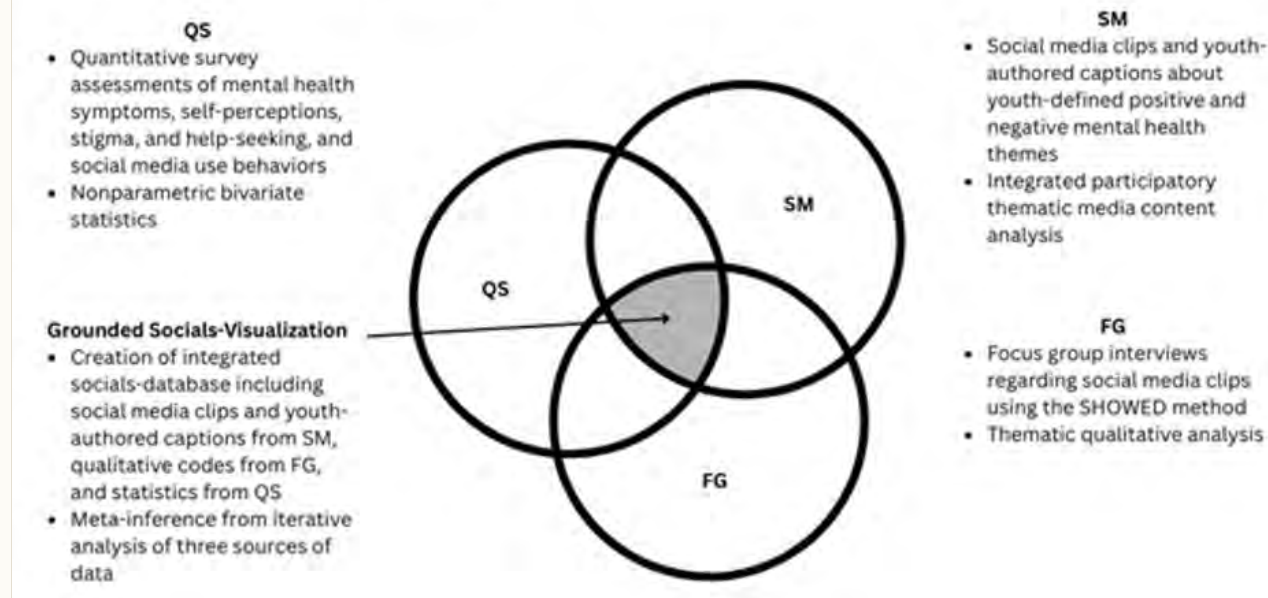
Method: Using a convergent mixed-methods randomized design, youth ages 13–24 years (N=41; September 2024–March 2025) from U.S. community-based organizations were randomly assigned to share social media clips depicting positive or negative mental health content, as defined by youth. In seven video-chat group sessions, youth discussed clips, authored captions, screened co-created summary videos, and completed pre-posttests. Grounded Socials-Visualization triangulated participant-donated social media clips, qualitative insights from group meetings, and nonparametric statistics to form meta-inferences (confirmation, discordance, expansion) about participatory effects on mental health symptoms, self-perceptions, stigma, and social media use behaviors. Moderation of results was explored among youth who screened at baseline as high risk of clinical mental health problems (n=31; 75.6%) on a combination of DISC, CES-DC, and PHQ-4 screeners.

Results: Overall, the negative vs positive theme group improved CES-DC and PHQ-4 scores ($p<.05$) but not self-rated mental health ($p<.01$). Mental illness knowledge/attitudes declined in both groups while social willingness improved in the negative group only; these trends were not significant. The negative vs positive group reduced neurobiological and increased psychosocial causal attributions ($p<.10$). Lastly the negative vs positive group reduced social media problem use, online contacts, peer comparison, and body/image concerns, though not significant. The presentation will share joint display tables of mean scores with social media and qualitative excerpts to form meta-inferences as well as discuss moderation by baseline mental illness.

Conclusion: SocialVoice goes beyond typical data science by power-sharing to co-create an integrated database of real-world social media experiences documenting both the harms and benefits of social media for mental health depending on the content. In addition, to advance pragmatic policy about social media safety and utility, a free educational book on SocialVoice findings was sent to participants, policymakers and key stakeholders.

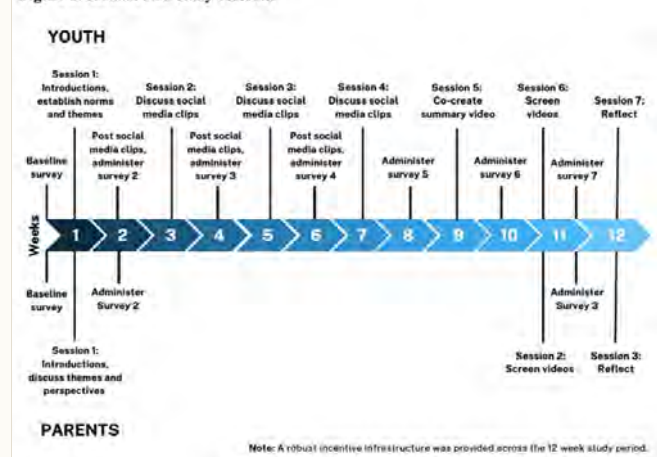
SocialsVoice study design, timeline and outcomes

Figure 1. *SocialsVoice* Convergent Mixed Methods Study Design to Triangulate Data Sources and Conduct Grounded Socials-Visualization

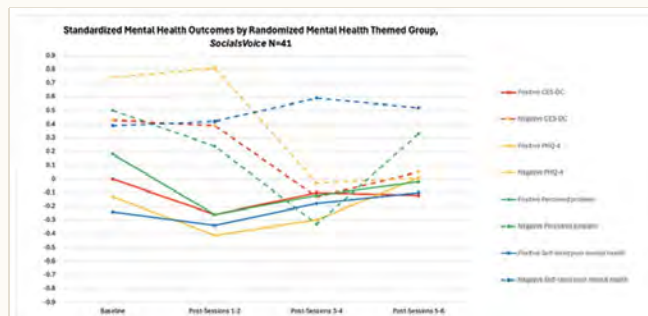


IMG 1 · CONVERGENT MIXED METHODS DESIGN

Figure 2. *SocialsVoice* Study Timeline



IMG 2 · STUDY TIMELINE



IMG 3 · STANDARDIZED OUTCOMES

A structural equation modeling framework to explore the risk factors of psychotic illness severity among people with schizophrenia in Ethiopia: Results from the NeuroGAP-Psychosis study

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Introduction: Mental health and substance use disorders impose a persistent global public health burden, yet the causes and risk factors of severe mental illness (SMI) remain insufficiently understood. Epidemiological evidence indicates that substance use, stress, poor physical well-being, and major life events exacerbate illness severity, increasing morbidity and mortality. This study examines the direct and indirect associations between these determinants to better understand their individual and interaction effects.

Methods: Data were drawn from NeuroGAP-Psychosis, focusing on individuals with schizophrenia spectrum disorder (SSD) in Ethiopia. The Mini International Neuropsychiatric Interview (MINI) was used as a proxy for current illness severity. Substance use was assessed using the ASSIST, while physical illness and stressful life events were evaluated using the CIDI and LEC-5. Structural equation modeling (SEM) with maximum likelihood estimation was applied to examine direct and indirect effects. Model fit was assessed using χ^2 , RMSEA, and CFI.

Results: Of 6,500 participants, 4,880 met SSD criteria (mean age 37.7 years, SD = 10.4). Medical condition was reported by 36%, physical assault by 32%, and transport accidents by 10.7%. Current substance use was 16.4% for tobacco, 17.9% for alcohol, and 22.1% for khat; 14.8% reported polysubstance use. Auditory-hallucinations (29.8%) and bizarre-delusions (22.3%) were the most common symptoms. Polysubstance use showed a strong association with male sex ($\beta = 0.577$) and was linked to higher stress and medical comorbidity. Psychotic illness severity was primarily driven by polysubstance use ($\beta = 0.337$) and stress ($\beta = 0.103$), with additional effects from education and marital status. Indirectly, sociodemographic factors influenced severity through polysubstance use, while stress affected severity both directly and indirectly through increased polysubstance use ($\beta = 0.029$). Overall, despite relatively small individual coefficients, stress and polysubstance use played central mediating roles, linking sociodemographic and medical conditions to psychotic illness severity.

Conclusion: These findings highlight the interconnected role of behavioral, social, and clinical factors in SMI, identifying stress and polysubstance use as key drivers of illness severity. Integrated interventions targeting substance use and stress management are essential to reduce the burden of SMI. Further research should explore causal pathways and context-specific interventions in low-resource settings.

Childhood trauma and probable ICD-11 Complex PTSD among trauma-exposed adults in Kenya and Uganda

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Introduction: Complex post-traumatic stress disorder (cPTSD) is characterized by the core symptoms of PTSD together with persistent disturbances in self-organization following repeated, prolonged, or inescapable traumatic experiences, particularly during childhood. Despite the high burden of childhood adversity in sub-Saharan Africa, epidemiological evidence on the relationship between childhood trauma and cPTSD remains limited. We examined the relationship between childhood trauma and probable current ICD-11 cPTSD among trauma-exposed adults in Kenya and Uganda.

Methods: We conducted a cross-sectional analysis of data from the Genetics of PTSD in Africa (GPAA) study. Childhood trauma was assessed using the Childhood Trauma Questionnaire (CTQ), comprising five domains: emotional, physical and sexual abuse, and emotional and physical neglect. Probable current ICD-11 cPTSD was assessed using the International Trauma Questionnaire (ITQ). Multivariable logistic regression examined associations between childhood trauma and probable current cPTSD using three exposure measures: standardized total CTQ score, CTQ quartiles, and individual CTQ domains. Sensitivity analyses were conducted by sex, excluding co-occurring mental health disorders, and combining both approaches. The outcome was probable current ICD-11 cPTSD, with probable non-complex PTSD and no PTSD forming the reference group.

Results: Among 3,046 trauma-exposed adults, 158 met criteria for probable current ICD-11 cPTSD, corresponding to a prevalence of 5.2%. Higher childhood trauma exposure was strongly associated with probable cPTSD. Each SD increase in CTQ score was associated with higher odds of probable cPTSD (OR 2.64, 95% CI: 2.30–3.03). After adjustment, the association remained significant (adjusted OR=1.66, 95% CI: 1.39–1.98). All childhood trauma domains demonstrated dose-response relationships with probable cPTSD, with abuse domains showing stronger associations than neglect. Emotional abuse demonstrated the strongest association; participants reporting severe emotional abuse had more than fourfold higher odds of probable cPTSD than those reporting none (adjusted OR=4.25, 95% CI: 2.37–7.61). Associations were consistently stronger among women than men.

Conclusions: Childhood trauma is strongly associated with current cPTSD symptoms among trauma-exposed adults in Kenya and Uganda, with emotional abuse emerging as the strongest correlate. These findings provide epidemiological evidence from sub-Saharan Africa and underscore the need for early childhood interventions, trauma-informed parenting programmes, and prevention strategies that address childhood maltreatment.

Early-onset and socially patterned mental health burden among university students: A campus-wide WMH-ICS study in Northern Italy

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Introduction: Universities are increasingly recognised as strategic settings for early identification, prevention and equity-oriented mental health promotion. However, student mental health surveillance often remains fragmented, symptom-specific, and poorly comparable across countries. Using a university-wide implementation of the World Mental Health International College Student (WMH-ICS) framework at the University of Pavia, Northern Italy, we examined whether students' mental health needs were concentrated in specific diagnostic domains or reflected a broader, socially patterned burden, with onset largely preceding university entry.

Methods: We analysed data from an anonymous online survey conducted as part of the Health Mode On project between July 2025 and February 2026. The survey invited doctoral, undergraduate and postgraduate students and used validated Composite International Diagnostic Interview-based screening scales with WMH-ICS scoring algorithms. Post-stratification weights based on the age and sex structure of the invited population were applied. We estimated weighted lifetime and 12-month prevalence of screening-positive mental disorders, described age-of-onset distributions, and used multivariable logistic regression to identify equity-relevant correlates of any mental disorder.

Results: A total of 7,414 students participated. Screening-positive mental health burden was high and strongly comorbid: 79.5% (95% CI 78.5–80.5) screened positive for at least one lifetime disorder and 64.4% (63.2–65.6) for at least one 12-month disorder; 60.4% and 40.4%, respectively, screened positive for two or more disorders. PTSD screening was the most frequent condition (55.5% lifetime; 42.6% 12-month), followed by anxiety disorders, eating disorders, mood disorders and the suicidal dimension. The median age of onset for any disorder was 15 years (IQR 13–18), indicating substantial pre-university onset. In adjusted models, the strongest correlates were childhood adversities (adjusted odds ratio 3.61 lifetime; 2.79 12-month), discrimination (2.32; 1.84) and inadequate financial resources (1.86; 1.95). Female sex, sexual minority status and academic delay were also independently associated with higher odds.

Conclusion: Mental health needs in this Italian university population were not confined to single disorders, but reflected an early-onset, highly comorbid and socially patterned burden. Findings support campus-level mental health strategies that combine low-threshold care, early detection and equity-oriented prevention addressing adversity, discrimination and financial strain.

Evaluating the evidence for psychosocial interventions to improve mental health in university students: An umbrella review

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Introduction: Mental health conditions are increasingly affecting university students worldwide. We conducted an umbrella review to evaluate the overall strength and certainty of the evidence regarding the effectiveness of psychosocial interventions for improving mental health outcomes in this population.

Methods: We included systematic reviews with meta-analyses of randomized controlled trials investigating psychosocial interventions among university students. Searches were conducted in Medline, PubMed, Cochrane Central, PsycINFO, CINAHL, Epistemonikos, and the Campbell Collaboration for studies published between January 1, 2014, and February 1, 2026. Random-effects meta-analyses using inverse-variance weighting and restricted maximum likelihood estimation were performed. Evidence was classified according to umbrella review criteria, while methodological quality and certainty of evidence were assessed using AMSTAR-2 and GRADE, respectively.

Results: Thirty-four systematic reviews were initially identified. After removing overlapping evidence, 28 independent meta-analyses from 12 systematic reviews were included. Mindfulness-based interventions compared with inactive controls demonstrated the strongest evidence for reducing psychological distress (SMD = -0.40, 95% CI -0.53 to -0.28), reaching highly suggestive evidence (Class II), with low certainty according to GRADE and high methodological quality according to AMSTAR-2. Suggestive evidence (Class III) was observed for mindfulness-based interventions on anxiety and depression, cognitive-based interventions on anxiety, depression, and well-being, positive psychology interventions on distress, and multimodal interventions on distress. Most of the remaining associations were either weak or statistically non-significant and were generally supported by evidence of low or very low certainty and methodological quality.

Conclusions: Mindfulness-based and cognitive-based interventions consistently showed the most reliable evidence for improving depression, anxiety, distress, and well-being in university students. Positive psychology interventions also demonstrated promising effects, although the overall certainty of the evidence remains limited. Further high-quality research is warranted to strengthen the available evidence base.

Oral Presentations Session 3

Thursday, October 1st, 2026

(OP 15 – OP 20)

Longitudinal prediction of adolescent depression across the life course using multivariable machine learning

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Introduction: Depression is a leading cause of disability worldwide, with onset peaking in adolescence. Identifying risk and protective factors across development is critical to informing targeted prevention. Machine learning methods offer an opportunity to simultaneously examine a broad range of developmental influences and identify the most robust predictors of adolescent depression within the context of each other.

Method: Data were drawn from Waves 1-7 (child age 4/5 to 16/17 years) of the Longitudinal Study of Australian Children (LSAC), a nationally representative birth cohort study (n = 4,983). A total of 174 child- and parent-reported predictors spanning sociodemographic, mental health, parenting, peer, and environmental domains across childhood and early adolescence were used to predict probable depression at age 16-17 years, indexed by the Short Mood and Feelings Questionnaire (score ≥ 12). Elastic net regression was implemented within a nested cross-validation framework (5-fold, repeated 3 times) for robust model evaluation and hyperparameter tuning. Feature importance was ranked by pooled absolute coefficients across folds, and stability selection identified robustly selected predictors.

Results: 21.1% of participants met criteria for probable depression at age 16-17. The model achieved an AUC of 0.74 (95% CI: 0.723-0.756), exceeding all 100 permuted AUCs (p < 0.01). Top predictors included self-harm ideation, suicide plan, and self-harm (all age 14), housing insecurity, female sex, emotional problems, anxiety, and low paternal closeness. In a sensitivity analysis removing self-harm and suicidal ideation predictors, the model retained acceptable performance (AUC = 0.72), with housing insecurity, parental closeness, emotional problems, and lack of social support emerging as the strongest predictors, highlighting modifiable targets for prevention.

Conclusion: Machine learning applied to a large longitudinal cohort identified a diverse array of individual, familial, and environmental predictors of adolescent depression spanning the full developmental period from early childhood to mid-adolescence. Findings underscore the importance of examining risk across the life course simultaneously and highlight housing insecurity and relational factors as promising targets for population-level prevention of adolescent depression.

Objectively measured physical activity and metabolic phenotypes in bipolar disorder: A cross-sectional study from the BIPCOM cohort

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Background: The BIPCOM project aims to investigate MC, specifically MetS, in individuals with BD using various approaches. Initially, prevalence rates, characteristics, genetic and non-genetic risk factors, and the natural progression of MetS among individuals with BD will be assessed by analysing Nordic registers, biobanks, and existing patient datasets from 11 European recruiting centres across 5 countries. Subsequently, a clinical study involving 400 participants from these sites will be conducted to examine the clinical profiles and incidence of specific MetS risk factors over 1 year. Baseline assessments, 1-year follow-ups, biomarker analyses, and physical activity measurements with wearable biosensors, and focus groups will be performed. Physical activity (PA) may improve metabolic and inflammatory health, but evidence based on objective activity measures and broad biomarker panels remains limited. In this presentation we will report on the first BIPCOM data, studying the association between PA and biomarkers.

Methods: We conducted a cross-sectional analysis of baseline data from 149 adults with BD (mean age 43.2 ± 13.4 , 56% female) enrolled in the BIPCOM cohort in 11 sites in 5 countries. Seven-day wrist actigraphy was used to derive average PA, and fasting blood samples were analysed for 21 metabolic and inflammatory biomarkers. Associations were examined using correlation analyses, exploratory factor analysis, and person-centred clustering.

Results: Higher average PA showed modest positive correlations with adiponectin and high-density lipoprotein cholesterol and negative correlations with serum amyloid A, tumor necrosis factor- α , high-sensitivity C-reactive protein, interleukin-6, and triglycerides, indicating a generally more favourable metabolic and inflammatory profile. Person-centred clustering identified three clinically interpretable profiles. Notably, the cluster with the highest metabolic burden (metabolic syndrome prevalence 44%) showed PA levels close to those of the healthiest cluster (2%), indicating substantial heterogeneity in the PA-metabolism relationship. This high-burden cluster also showed the poorest social functioning, suggesting that its disadvantage extended beyond metabolic health.

Conclusions: Objectively measured PA was associated with a more favourable biomarker profile in BD, but PA volume alone was not a sufficient marker of metabolic health. These exploratory findings support profile-specific, multimodal prevention combining activity promotion with dietary, weight-management, and medication-related metabolic monitoring.

Can community mental health work promote wellbeing in contexts of migration, war, and uncertainty? Results from a Pilot RCT with Syrian refugee young adults in Lebanon

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Mental health consequences of displacement are significant, and often human resources for health promotion are not sufficient. A large proportion of refugee populations are young adults (YA), and evidence indicates that engaging them in work that supports their communities leads to their own enhanced wellbeing and that of their community.

This 3-arm pilot trial trained Syrian refugees YA (18–24 yrs.) to serve their communities as Community Mental Health Workers – CMHW (n=19) or tutors (n=19) and compares wellbeing, stress and coping outcomes between these two groups and a comparison group (n=40). We assessed 7 positive mechanisms as potential pathways for the interventions to influence outcomes in YA.

This presentation will describe baseline (T1) and time 2 (halfway through intervention) survey results between the three trial arms. In addition to descriptive analysis, we present a multiple mediation approach to examine the estimated direct and indirect effects of the active intervention arms relative to the control group. Overall, the participants in our study experienced substantial hardship, with significant decrease in wellbeing overall over time. Across all groups, wellbeing and adaptive coping declined over time, while stress and maladaptive coping increased. A consistent pattern emerged, with the CMHW group demonstrating the most favorable outcomes, followed by the control group and then the tutor group. Although intervention effects were initially evident, they appeared to attenuate over time.

In the mediation analyses, we find consistent evidence that the tutoring group showed significant negative total indirect and total effects for wellbeing, a significant and positive total indirect effect for maladaptive coping, and a significant positive total indirect and total effect for stress. Meanwhile, the CMHW group showed a significant total effect in decreasing maladaptive coping, which may not have primarily transmitted through the measured mechanisms. We conclude that in the contexts of chronic uncertainty and discrimination, intervention effects alone may not be strong enough to supersede the impact of trauma. Refugee young adults can play meaningful community roles, but support structures are critical to protect their wellbeing.

Understanding ADHD in Kenyan children: Prevalence, subtypes, and psychosocial factors from a tertiary clinic

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Introduction: Attention-deficit/hyperactivity disorder (ADHD) is one of the most common neurodevelopmental disorders of childhood and is associated with significant academic, social, and emotional impairment. Although ADHD has been widely studied in high-income settings, data on its prevalence, subtypes, and psychosocial correlates in sub-Saharan Africa remain limited. This study aimed to determine the prevalence of ADHD and examine associated psychosocial and perinatal factors among children attending a tertiary child psychiatry clinic in Kenya.

Methods: An analytical cross-sectional study was conducted at the Child Psychiatry Clinic of Kenyatta National Hospital. Children aged 3–17 years were recruited using simple random sampling. Data were collected using a structured sociodemographic and psychosocial questionnaire and the Kiddie-Schedule for Affective Disorders and Schizophrenia – Present and Lifetime (K-SADS-PL), administered to caregivers and participants. Descriptive statistics summarized participant characteristics and ADHD subtypes. Associations between ADHD symptom domains and sociodemographic, psychosocial, and perinatal factors were examined using chi-square tests and logistic regression. Statistical significance was set at $p < 0.05$.

Results: A total of 106 children participated (73.6% male), with a mean age of 6.22 ± 3.18 years. The prevalence of ADHD was 78.3% among clinic attendees. The predominantly inattentive subtype was most common (44.6%), followed by combined type (34.9%) and predominantly hyperactive-impulsive subtype (20.5%). Inattentive domain scores were significantly associated with difficulties in social relationships during childhood, at school, and within the neighbourhood. Hyperactive-impulsive domain scores were significantly associated with prematurity and neighbourhood relational factors. In multivariable analysis, prematurity remained strongly associated with hyperactive-impulsive symptoms.

Conclusion: ADHD represents a substantial burden among children attending specialist psychiatric care in Kenya. Both psychosocial and perinatal factors appear to influence symptom presentation and subtype expression. These findings highlight the importance of comprehensive, context-sensitive assessment and interventions that incorporate family, school, and community-level support in the management of ADHD in low-resource settings.

Precision psychological care for children affected by humanitarian crises: The PEACE project

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Introduction: Children exposed to humanitarian crises, including armed conflict, forced displacement, extreme poverty and natural disasters, face an elevated risk of psychological distress and post-traumatic stress disorder (PTSD). Evidence on the effectiveness of mental health and psychosocial support interventions (MHPSS-I) for these children remains inconsistent, and some interventions may even impede recovery. Critically, existing evidence is reported at group level, obscuring substantial individual differences in response and offering no guidance on which intervention suits which child. PEACE (Precision Evidence-based psychological Aid for Children in Emergency) addresses this gap by developing and testing a precision psychological care algorithm for children affected by humanitarian emergencies.

Method: PEACE is structured in three sequential phases. First, network meta-analytic techniques are applied to individual participant data (IPD) pooled across existing MHPSS-I trials, generating person-level prediction models of intervention response and complementary mediation analyses of underlying mechanisms of action. Second, the harmonised IPD dataset is used to train a machine-learning algorithm able to predict how, under what circumstances, and for which child a specific MHPSS-I will reduce PTSD symptoms and improve functioning and wellbeing. Third, the algorithm will be prospectively tested in an enrichment-design randomized controlled trial, a precision-care methodology not previously applied in mental health research.

Results: PEACE is a five-year ERC Consolidator Grant project that started in June 2026. This contribution presents the project's rationale, multi-phase design, and current implementation status, including the protocol for systematic identification and harmonisation of IPD eligible for the network meta-analysis. Ethical safeguards specific to the involvement of highly vulnerable minors and to the use of an AI-based prediction system have been established ahead of data collection.

Conclusion: By replacing the "one-size-fits-all" approach with individualised, evidence-based allocation of MHPSS-I, PEACE aims to maximise treatment benefit while reducing unnecessary risk exposure for children affected by humanitarian crises, advancing both equity and innovation in mental health science and care for populations affected by global disruption and displacement.

Funding: This project has received funding from the European Research Council (ERC) under the European Union's Horizon Europe research and innovation programme (Grant Agreement No. 101231883).

Who founded the mental health population sciences and psychiatric epidemiology? Answers almost everyone has missed

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Introduction: For many in our field, the list of founders of psychiatric epidemiology and mental health population sciences starts with William Farr and Edward Jarvis, for their mid-19th-century contributions, or with Faris and Dunham (1939). But what about Holst, Jacobi, Koch, and Engel, whose European survey estimates predate and parallel this history? Or Aaron Rosanoff, whose 1916–1917 Nassau County survey might qualify as the earliest community survey to yield disorder-specific prevalence estimates for mental disorders in the United States, distinct from the coarser insane/idiotic classifications used in prior federal census work? Or the almost entirely neglected Ruth Fairbank, “psychiatrist in charge” of one of the first community-based mental hygiene surveys in an American city, six years before Faris and Dunham? Their work challenges any assumption that disorder-specific prevalence estimates were not attempted until later in the 20th century.

Method: Archival trace and citation-pattern analysis (Bidirectional Recursive Historical Scanning, BRHS) identified these 19th-century contributors, plus Rosanoff and Fairbank. BRHS traced authorship structures, institutional acknowledgments, and citation patterns against three criteria distinguishing structured non-citation from ordinary disciplinary siloing: institutional proximity, methodological equivalence, and identity-correlated patterning across cases.

Results: Estimates derived by European pioneers of generally neglected key-informant surveys, including Holst’s disorder-specific prevalence estimates (mania, melancholia, dementia, idiotia), are shown alongside Fairbank’s and Rosanoff’s. Fairbank was “psychiatrist in charge” of a 1933 Baltimore survey, yet was subordinated to statistician Bernard Cohen in authorship order for reasons the record does not explain. Her last appearance in the survey’s authorship list was in 1939; later papers in the series replaced her name with a successor’s. Rosanoff’s community survey findings were themselves sound, but his standing was subsequently discredited by association with his separately flawed 1911 Mendelian-heredity study — reputational contamination, distinct from the negative-space citation seen elsewhere in this record.

Conclusion: Any complete account of the founders of mental health population sciences must credit some often-neglected founders in a European key-informant survey tradition. This tradition laid groundwork for disorder-specific estimates from American community surveys in 1916–17 and after 1933, carrying forward toward today’s multi-country surveys, now with more standardized and direct assessments of community residents.



Poster Session I

Wednesday, September 30th, 2026

(PP 01 - PP 30)

Artificial intelligence in mental health care for migrants and refugees: Cultural dimensions, risks, and implications for psychiatric nursing - A scoping review

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Introduction: Global migration has increased the cultural complexity of mental health care, with migrants, refugees, and asylum seekers facing heightened vulnerability due to trauma, social exclusion, and barriers to accessing culturally appropriate services. While artificial intelligence offers new opportunities for screening, prediction, and care optimization, its use in this field raises concerns related to bias, cultural validity, safety, and ethical governance. Despite growing interest, there is limited synthesis on how AI applications integrate cultural care principles, highlighting the need for critical and evidence-informed analysis. The aim of this study was to map the use of artificial intelligence (AI) in mental health care for migrants, refugees, and asylum seekers; to describe reported outcomes and effects, to identify risks and safeguards.

Methods: A scoping review was conducted in accordance with the JBI methodology. The studies were selected based on the Population, Concept, and Context (PCC) criteria, using the PRISMA flowchart. Data was charted to describe the body of literature according to the review research questions.

Results: 28 studies were included. Its findings indicate that AI has been used predominantly for prediction, screening/triage, classification, and operational decision support, with a strong presence of Machine Learning (ML) and low representation of LLMs/generative AI. The field shows early-stage maturity and a predominance of non-clinical outcomes. Studies reporting interventions and clinical outcomes were identified; however, they do not support broad generalizations for clinical use. Recurring risks were identified, including classification errors, stigma, automation, privacy and data security concerns, as well as exclusion related to barriers in access and language. Cultural analysis suggests that culture is most often addressed through language, access, stigma, and trauma, while more relational and transformative components of culturally congruent care tend to be less explicitly described.

Conclusion: Responsible integration of AI in mental health care for migrants and refugees requires rigorous evaluation, clear safeguards, human oversight, and culturally informed, equity-oriented implementation. The results indicate both an opportunity and a responsibility for mental health professionals to actively participate in defining safety criteria, cultural adequacy, and governance, ensuring that innovation translates into ethical, safe, and person-centered care.

Knowledge, attitudes and practices towards community cardiac rehabilitation and multimorbidity in Pakistan: A mixed methods study

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Introduction: Cardiovascular diseases (CVDs) drive substantial mortality in Pakistan where multimorbidity involving depression and anxiety is common and often unmanaged. Community cardiac rehabilitation (CCR) offers an evidence based approach to improving cardiac and mental health outcomes, yet CCR access in low resource settings remains extremely limited. Understanding health professionals' knowledge, attitudes, and practices is essential for designing equitable, scalable CCR models that integrate mental health needs.

Methods: We conducted a mixed methods feasibility study involving an online cross sectional survey and semi structured interviews with healthcare professionals providing cardiac care. A total of 940 respondents—including cardiologists, nurses, physiotherapists, technicians, and general physicians—completed the survey. We analysed quantitative data descriptively and inferentially, and used thematic analysis to explore perceived barriers, facilitators, and readiness for CCR implementation.

Results: Participants demonstrated high awareness of cardiac rehabilitation (83.8%) and CCR (76.6%), yet only 37.9% reported formal training. Most respondents (96.1%) had treated patients with multimorbidity involving depression or anxiety, reinforcing the need for integrated mental health support. Major barriers to CCR participation included financial constraints (88.3%), lack of community based programmes (80.6%), transport difficulties (90.2%), and low socio economic status (82.0%). Participants strongly endorsed community based delivery (98.3%), physician referral (97.2%), and primary care integration (97.4%) as facilitators. Digital delivery received broad support (95.4%), with mobile app based rehabilitation preferred (52.6%). Interview findings reinforced gaps in training, infrastructure, and mental health capability, and highlighted the need for culturally appropriate, accessible CCR models.

Conclusion: Healthcare professionals in Pakistan recognise the importance of CCR and the central role of mental health multimorbidity in cardiac care, yet substantial structural barriers limit implementation. Strengthening professional training, expanding community based CCR infrastructure, and integrating digital and blended delivery models could improve access and equity. Embedding mental health support within CCR represents an important opportunity to advance innovation in secondary prevention and address disparities in cardiac and psychological care in low resource settings.

Funding: National Institute for Health and Care Research (NIHR) Proposal and Partnership Development Award (NIHR205539)

Bridging gaps in youth mental health care: YOUTHreach—a comprehensive European strategy

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Background: Europe is facing a mental health crisis that will last for decades, impacting the long-term health outcomes, wellbeing and economic productivity of young people. Yet, large-scale, comparative research of youth-friendly mental health interventions is lacking. The YOUTHreach consortium aims to bridge this gap and provide a comprehensive European strategy. Nearly half of all young people in Europe report unmet mental health care needs, with merely 20–30% of those experiencing mental health problems receiving care. Barriers towards adequate help include (self-)stigma, insufficient mental health literacy. Over the last decades, promising developments have emerged aimed at transforming the traditional mental health care system, providing youth-friendly support for people aged 12–25 years and overcoming the harmful service split around the age of 18. The best-known examples are the Australian headspace walk-in centres. Additionally, with many young people using mobile phones, youth mental interventions should also innovate digitally, and promising results have been found for a guided self-help daily life intervention (SELFIE). These promising interventions are currently at different stages of maturity in terms of implementation and validation and face substantial gaps in their evidence base. The YOUTHreach consortium, consisting of 8 European countries (Belgium, Estonia, Germany, Ireland, Italy, Netherlands, Spain, United Kingdom) and Australia, will address these gaps.

Aims: For this purpose, YOUTHreach will evaluate the clinical effectiveness and cost-effectiveness of three existing and accessible innovative interventions for prevention and early intervention of mental ill-health in youth, developed and tested in co-creation with youth: 1) YEAH, walk-in youth mental health support centres; 2) SELFIE, a transdiagnostic blended ecological momentary intervention; and 3) MOST, a clinical and peer-moderated digital youth mental health platform. In addition, feasibility and acceptability at new sites across Europe will be tested. Furthermore, in partnership with young people, best practice recommendations will be developed based on existing and new data.

Results: Awareness and accessibility of these interventions among policymakers, healthcare professionals, the general public, and youth—the target group—will be raised. YOUTHreach aims to contribute towards transformation of the present traditional mental healthcare system and providing the next generation with a better perspective in terms of health, wellbeing and productivity.

Ecological monitoring of physical activity, emotions and daily life activities in schizophrenia: the DiAPAsen study

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IRCCS Fatebenefratelli, Brescia, Italy

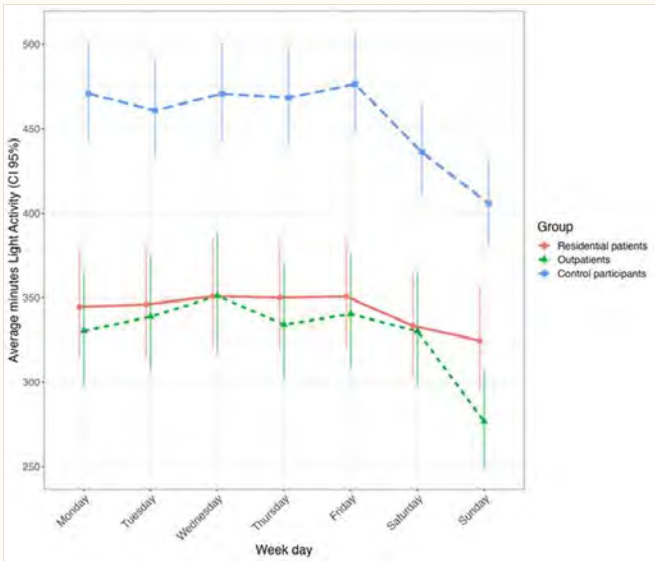
Background: Schizophrenia spectrum disorders (SSD) are ranked among the leading causes of disabilities worldwide. Many people with SSD spend most of their daily time being inactive, and this is related to the severity of negative symptoms. Here, we present the 3-year DiAPAsen project aimed at (1) evaluating the daily time use among patients with SSD living in Residential Facilities (RFs) compared to outpatients with SSD and to the general population (Study 1); (2) evaluating the quality of staff-patient relationships, its association with specific patient outcomes and the quality of care provided in RFs (Study 2); and (3) assessing daily activity patterns in residential patients, outpatients with SSD and healthy controls using real-time methodologies (Study 3). We performed a cohort study aimed at investigating: (1) the differences in physical activity (PA), daily activities and emotions between patients with SSD and healthy controls (HC); (2) the strength of the association between these variables and clinical features among patients with SSD.

Methods: 37 mental health services across all Italy were involved in the DIAPASON project. In this subproject ninety-nine patients with SSD (53 residential patients, 46 outpatients) and 111 matched HC were assessed for several clinical variables, and levels of functioning by means of standardised clinical measures. Self-reported daily activities and emotions were assessed with a smartphone application for ecological momentary assessment (EMA), and PA levels were assessed with a wearable accelerometer for 7 consecutive days.

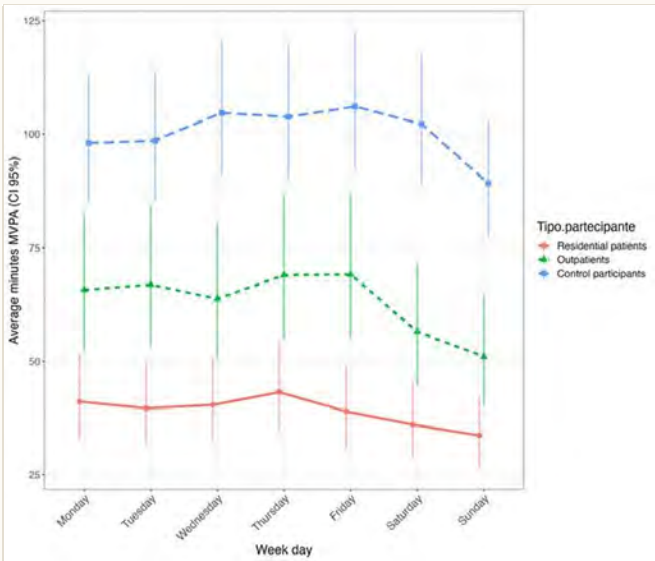
Results: Patients with SSD, especially those living in residential facilities, spent more time being sedentary, and self-reported more sedentary and self-care activities, experiencing higher levels of negative emotions compared with HC. Moreover, higher functioning levels among patients were associated with more time spent in moderate-to-vigorous activity.

Conclusions: Sedentary behaviour and negative emotions are particularly critical among patients with SSD and are associated with more impaired clinical outcomes. Clinical implications Mobile-EMA and wearable sensors are useful for monitoring the daily life of patients with SSD and the level of PA. This population needs to be targeted with specific rehabilitative programmes aimed at improving their commitment to structured daily activities.

Daily physical activity by group, DiAPAson study



IMG 1 · LIGHT ACTIVITY



IMG 2 · MVPA

Metabolic risk profile in adults treated with second-generation antipsychotics: Findings from the RISKMET PROJECT

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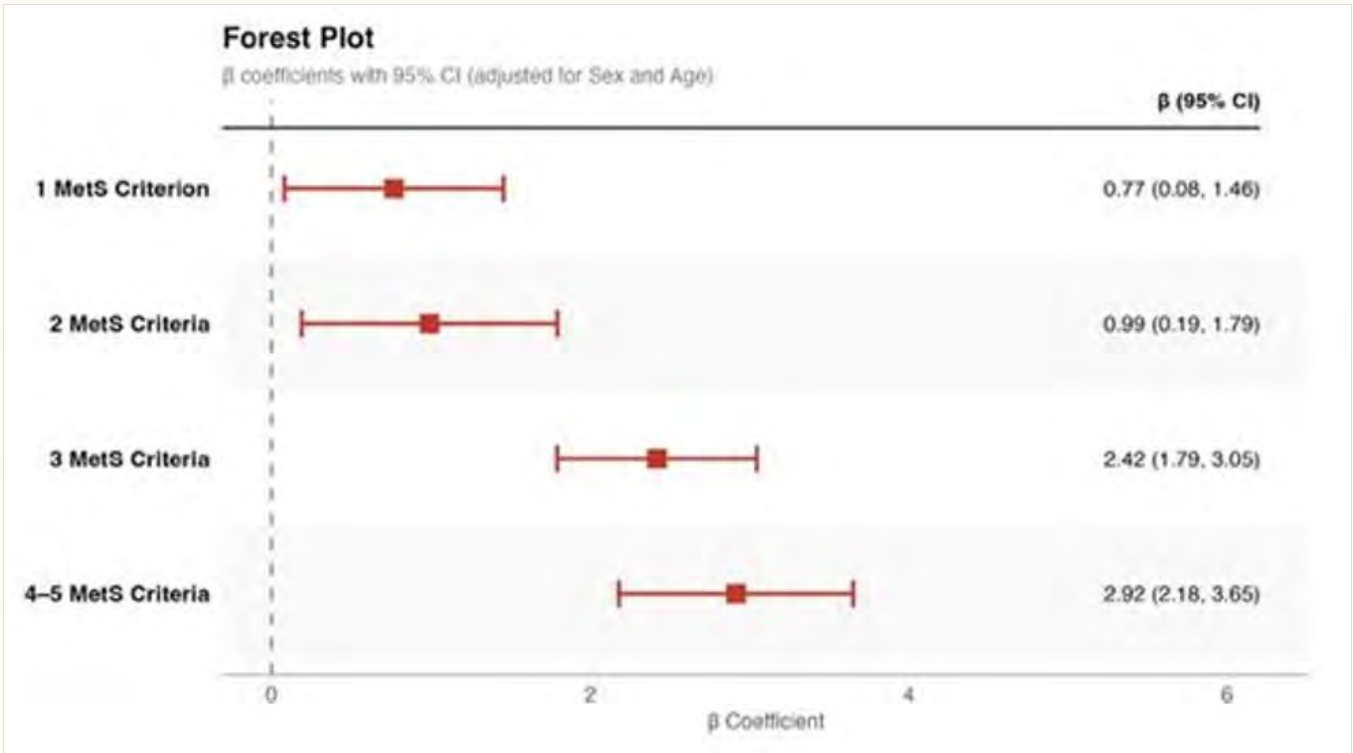
Introduction: Adults with schizophrenia spectrum disorders or bipolar disorder treated with second-generation antipsychotics (SGAs) are at increased risk of metabolic syndrome (MetS), but early metabolic dysfunction may remain undetected when only categorical MetS definitions are used. This study aimed to compare the clinical, metabolic, biomarker, and pharmacological profiles of SGA-treated adults with and without MetS, and to assess whether the Liver Fat Score identifies early metabolic impairment across increasing MetS severity.

Method: This case-control analysis was conducted within the multicentre Italian RISKMet project. Adults aged 18–65 years with schizophrenia spectrum disorders, bipolar I disorder, or bipolar II disorder treated for at least one year with olanzapine, risperidone, quetiapine, or aripiprazole were recruited at two centres. Participants were classified as MetS+ or MetS- according to NCEP ATP III criteria and additionally stratified by number of MetS criteria (0, 1, 2, 3, 4–5). Sociodemographic, clinical, pharmacological, anthropometric, and biochemical data were collected. Insulin resistance was estimated using HOMA-IR, and liver fat by the NAFLD Liver Fat Score. Group comparisons and age- and sex-adjusted linear regression analyses were performed.

Results: The final sample included 101 participants (45 MetS+, 56 MetS-). The groups were comparable in age, sex, diagnosis, illness duration, psychopathology, functioning, and current SGA treatment. Compared with MetS- participants, MetS+ participants showed significantly higher body mass index, waist circumference, fasting glucose, glycated haemoglobin, OGTT values, triglycerides, HOMA-IR, and medical comorbidity burden, and lower HDL cholesterol. Liver Fat Score was significantly higher in MetS+ than in MetS- participants (0.2 ± 1.2 vs -1.8 ± 1.0 ; $p < 0.001$). Regression analyses showed a progressive increase in Liver Fat Score with a greater number of MetS criteria, with significant elevations already at one and two criteria.

Conclusion: Metabolic risk in adults treated with SGAs appears to develop along a continuum rather than as a dichotomous condition. The Liver Fat Score may detect early hepatic metabolic dysfunction before full MetS is established and could support earlier cardiometabolic risk stratification in psychiatric populations.

Liver Fat Score by number of MetS criteria



IMG 1 · FOREST PLOT, B COEFFICIENTS WITH 95% CI

Caregivers' perceptions of respect for human rights in mental health and other healthcare services: A cross-sectional study in Sardinia, Italy

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Background: The Italian model of mental health care, developed after Law 180 of 1978, is one of the most influential examples of community-based psychiatry. It has promoted care grounded in human rights, participation, and respect for dignity. In a context marked by economic hardship and pressure on public health systems, understanding whether respect for human rights is still perceived as central across care settings is of growing public health relevance. This study compares caregivers' perceptions of respect for human rights in mental health and other healthcare settings.

Methods: A cross-sectional study included 175 informal caregivers of people in community mental health services and other healthcare services in Sardinia, Italy. The caregiver version of the Well-Being at Work and Respect for Human Rights Questionnaire (WWRR), based on a six-point Likert scale, was administered. Items 4 and 5 were selected as outcomes, assessing perceived respect for the human rights of service users and healthcare professionals, respectively. Multiple linear regression models were estimated, with perceived respect for human rights as the dependent variable and service type as the main independent variable, comparing community mental health with other healthcare services. Models were adjusted for age, sex, marital status, educational level, and employment status.

Results: Perceived respect for the human rights of service users and professionals was generally high. In multiple linear regression models, receiving care in mental health services, compared with other healthcare services, was the only factor consistently associated with more favourable perceptions of respect for human rights. This association was observed for service users, $\beta = 0.46$, 95% CI: 0.25–0.68, $p < 0.001$, and professionals, $\beta = 0.61$, 95% CI: 0.33–0.89, $p < 0.001$, adjusted for sociodemographic variables.

Conclusions: Caregivers of people receiving care in mental health services reported more positive perceptions of respect for human rights than caregivers in other healthcare settings. These findings suggest that, from the caregivers' perspective, respect for rights remains an integral part of the community mental health care model in Italy. Further research should examine factors influencing caregivers' perceptions of human rights across care settings.

Funding: QualityRights Project, Assessorato alla Sanità (Regione Sardegna). CUP: E77G23000370002.

Characteristics of caregivers by service type

Table 1. Characteristics of caregivers by service type: mental health services versus other healthcare services.

Variable	Mental health services (n = 74)	Other healthcare services (n = 101)	Comparison (p-value)
Age (years), Mean $\pm$ SD	57.42 $\pm$ 12.62	55.65 $\pm$ 14.54	t = -0.83 (p = 0.409)
Female	49 (66.2)	79 (78.2)	$\chi^2 = 3.13$ (p = 0.077)
Male	25 (33.8)	22 (21.8)	
Single	18 (24.3)	27 (26.7)	
Married	46 (62.2)	69 (68.3)	
Divorced	6 (8.1)	4 (4.0)	
Widowed	4 (5.4)	1 (1.0)	$\chi^2 = 4.54$ (p = 0.209)
Married (vs. Not married)	46 (62.2)	69 (68.3)	
Unemployed	19 (25.7)	22 (21.8)	
Employed	27 (36.5)	51 (50.5)	
Retired	28 (37.8)	27 (26.7)	
High school diploma	23 (31.1)	45 (44.6)	$\chi^2 = 0.71$ (p = 0.397)
University degree	14 (18.9)	22 (21.8)	
Middle school or lower	37 (50.0)	34 (33.7)	

Legend. Values are reported as frequency n (%) or mean $\pm$ standard deviation (SD). Comparisons between caregivers affiliated with mental health services and those affiliated with other healthcare services were performed using independent-samples t-tests for continuous variables, Pearson's chi-square (χ^2) tests for categorical variables, and Fisher's exact test when expected cell frequencies were small. P-values refer to between-group comparisons.

Note. An additional exploratory binary comparison of married versus not married is presented because some marital status groups contained small numbers of participants.

TABLE 1

Perceived respect for service users' rights

Table 2. Multiple linear regression model predicting perceived respect for service users' rights. WWRR Item 4 - To what extent do you believe that the human rights of users are respected in the service where your relative is cared for?

Predictor	β (SE)	t	p	95% CI
Mental health services (vs. other healthcare services)	0.464 (0.110)	4.23	<0.001	0.248, 0.680
Age (per year increase)	0.009 (0.008)	1.13	0.259	-0.007, 0.025
Male sex (vs. female)	-0.171 (0.122)	-1.40	0.164	-0.413, 0.071
Married (vs. single)	-0.044 (0.225)	-0.20	0.845	-0.487, 0.399
Divorced (vs. single)	0.103 (0.263)	0.39	0.695	-0.417, 0.624
Widowed (vs. single)	0.147 (0.267)	0.55	0.583	-0.380, 0.674
University degree (vs. high school diploma)	-0.011 (0.212)	-0.05	0.959	-0.429, 0.407
Lower education (vs. high school diploma)	-0.161 (0.128)	-1.25	0.212	-0.414, 0.093
Employed (vs. unemployed)	0.306 (0.191)	1.60	0.111	-0.071, 0.684
Retired (vs. unemployed)	0.267 (0.176)	1.52	0.131	-0.081, 0.616
Model statistics. $N = 170$; $F(10,159) = 3.53$; $R^2 = 0.120$; Root MSE = 0.816. Robust standard errors were used. Legend. β = unstandardized regression coefficient; SE = robust standard error; CI = 95% confidence interval; t = t statistic; p = p-value. Reference categories were: other healthcare services, female sex, single marital status, high school diploma, and unemployed status. Note. WWRR = Well-Being at Work and Respect for Human Rights Questionnaire. Items 4 and 5 were rated on a 6-point Likert scale, with higher scores indicating a more positive perception of respect for human rights. Sex was coded as female = 0 and male = 1. Age was included as a continuous variable.				

TABLE 2 · WWRR ITEM 4

Perceived respect for healthcare operators' rights

Table 3. Multiple linear regression model predicting perceived respect for healthcare operators' rights. WWRR Item 5 - To what extent do you believe that the human rights of the workers are respected in the service where your relative is cared for?

Predictor	β (SE)	t	p	95% CI
Mental health services (vs. other healthcare services)	0.611 (0.140)	4.36	<0.001	0.334, 0.888
Age (per year increase)	0.007 (0.008)	0.80	0.428	-0.010, 0.023
Male sex (vs. female)	-0.059 (0.160)	-0.37	0.711	-0.376, 0.257
Married (vs. single)	-0.264 (0.223)	-1.19	0.238	-0.704, 0.176
Divorced (vs. single)	-0.807 (0.367)	-2.20	0.029	-1.531, -0.083
Widowed (vs. single)	-0.202 (0.394)	-0.51	0.608	-0.980, 0.575
University degree (vs. high school diploma)	-0.175 (0.216)	-0.81	0.418	-0.601, 0.251
Lower education (vs. high school diploma)	-0.075 (0.169)	-0.44	0.658	-0.408, 0.259
Employed (vs. unemployed)	0.067 (0.233)	0.29	0.773	-0.392, 0.526
Retired (vs. unemployed)	0.005 (0.219)	0.02	0.983	-0.428, 0.438

Model statistics. N = 170; F(10,159) = 2.76; R² = 0.113; Root MSE = 0.957. Robust standard errors were used.

Legend. β = unstandardized regression coefficient; SE = robust standard error; CI = 95% confidence interval; t = t statistic; p = p-value. Reference categories were: other healthcare services, female sex, single marital status, high school diploma, and unemployed status.

Note. WWRR = Well-Being at Work and Respect for Human Rights Questionnaire. Items 4 and 5 were rated on a 6-point Likert scale, with higher scores indicating a more positive perception of respect for human rights. Sex was coded as female = 0 and male = 1. Age was included as a continuous variable.

TABLE 3 · WWRR ITEM 5

Demographic predictors and moderators of anxiety reduction in transdiagnostic group CBT for anxiety disorders

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Introduction: Transdiagnostic cognitive-behavior therapy (tCBT) is an evidence-based treatment for anxiety disorders. Few studies have examined predictors and moderators of treatment effectiveness in tCBT, and understanding individual characteristics associated with positive outcomes is essential to support evidence-informed tCBT delivery. In this study, we sought to explore whether there were predicting or moderating effects of demographic data and life stressors on tCBT effectiveness. We additionally considered severity at baseline and medication to enable comparison and to contextualize the present findings.

Method: The study is based on a secondary analysis of a multicenter single-blind, two-arm pragmatic superiority randomized trial comparing tCBT with treatment-as-usual (TAU) in community-based care. The sample comprised 231 participants aged 18–65 who met DSM-5 criteria for principal diagnoses of generalized anxiety, social anxiety, panic disorder, or agoraphobia. Participants were randomized to either tCBT + TAU (n = 117) or TAU (n = 114), with outcome data available for, respectively, 95 and 106. There were no restrictions for TAU. The outcome measure for the analysis was the Beck Anxiety Inventory (BAI) at post-treatment.

Results: Results of linear models adjusted for BAI at baseline suggest that the only predictive demographic factor associated with anxiety reduction was older age as a categorical variable (i.e., 55–65 vs 18–24). Higher anxiety or depressive symptoms at baseline were associated with higher anxiety level at post-treatment. For moderating factors, only depressive symptoms at baseline showed a significant effect, with tCBT demonstrating greater benefit than TAU at higher depressive symptom severity. No significant predictor or moderator was observed for sex, education, marital status, economic situation, life stressors, or medication.

Conclusion: As expected, higher baseline levels of anxiety or depressive symptoms remained at a higher level at post-treatment. However, our findings also indicate that group tCBT can result in symptom reduction in participants with diverse demographic profiles and experience of stressors, as well as concurrent medication. The findings underscore the need for further research on individual factors related to group composition, while also ensuring that there are no unwarranted disparities in access to tCBT based on variables such as life stressors or educational attainment.

Developing the Italian sign language versions (LIS) of the PHQ-9 and GAD-7 and testing their content and face validity: A Delphi study

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Introduction: According to the World Health Organization, over 450 million people worldwide experience hearing loss. Deaf individuals often face communication barriers and social marginalization that may negatively affect mental health. Evidence suggests a higher prevalence of depression and anxiety in this population. In Italy, validated mental health screening tools for deaf individuals are lacking. This study aims to develop accessible and culturally adapted Italian Sign Language (LIS) versions of the Patient Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder-7 (GAD-7).

Methods: A Delphi study involving 16 experts followed a five-stage forward-backward translation and cultural adaptation procedure. In Stage 1, five deaf bilingual Italian-LIS signers independently translated the PHQ-9 and GAD-7 into LIS. In Stage 2, an expert panel evaluated the five LIS versions of each item according to clarity, comprehensibility, semantic equivalence, linguistic naturalness, and appropriateness of non-manual components (NMC). In Stages 3 and 4, consensus-based LIS versions were established and back-translated into written Italian. In Stage 5, content and face validity are being assessed by a second expert panel, including deaf LIS signers. A consensus index of ≥ 0.75 was considered acceptable.

Results: The 16 items of the PHQ-9 and GAD-7 were independently translated into LIS and video-recorded by five deaf bilingual Italian-LIS signers, generating 80 item versions (Stage 1). For each eligible item across the five LIS versions, expert consensus index (CI) was as follows: clarity (PHQ-9/GAD-7) CI=0.85/0.90; comprehensibility CI=0.89/1; semantic equivalence CI=0.84/0.92; linguistic naturalness CI=0.90/1; and NMC appropriateness CI=0.90/0.94. For all 16 items, at least one translated version achieved the predefined consensus threshold (PHQ-9/GAD-7 ranges=0.80-0.97/0.93-0.95), eliminating the need for further revision or reconciliation (Stage 2). Consequently, the final consensus-based LIS versions of the PHQ-9 and GAD-7 were established (Stage 3) and back-translated into written Italian (Stage 4).

Conclusions: The development of consensus-based LIS versions of the PHQ-9 and GAD-7 represents an important step toward improving access to mental health assessment for deaf individuals in Italy. The final content and face validity evaluation is ongoing (Stage 5) and will be completed by July 2026, at which time results will be available.

Consensus index by category and item (GAD-7)

Table 1. Consensus Index about categories and items (GAD-7)

Sign version	GAD-7 items	Clarity	Comprehensibility	Semantic Equivalence	Linguistic Naturalness	Non-Manual Components	Total score	Consensus Index
A	1	8/9	9/9	8/9	8/9	8/9	42/45	0.93
	2	6/9	8/9	8/9	5/9	8/9	35/45	0.77
	3	7/9	7/9	7/9	8/9	8/9	37/45	0.82
	4	3/9	9/9	9/9	9/9	9/9	44/45	0.93
	5	8/9	9/9	9/9	7/9	8/9	41/45	0.91
	6	5/9	6/9	8/9	5/9	9/9	33/45	0.73
	7	3/9	9/9	8/9	9/9	9/9	43/45	0.95
B	1	9/9	9/9	9/9	9/9	7/9	44/45	0.93
	2	9/9	9/9	8/9	9/9	8/9	43/45	0.95
	3	8/9	6/9	8/9	8/9	8/9	38/45	0.84
	4	7/9	9/9	8/9	9/9	8/9	41/45	0.91
	5	7/9	8/9	6/9	9/9	8/9	38/45	0.84
	6	3/9	9/9	7/9	9/9	9/9	42/45	0.93
	7	6/9	8/9	5/9	9/9	9/9	37/45	0.82
C	1	7/9	8/9	3/9	9/9	9/9	37/45	0.82
	2	5/9	5/9	3/9	9/9	7/9	29/45	0.64
	3	8/9	9/9	8/9	9/9	8/9	42/45	0.93
	4	7/9	8/9	9/9	9/9	8/9	41/45	0.91
	5	7/9	9/9	9/9	9/9	9/9	43/45	0.95
	6	6/9	5/9	3/9	9/9	8/9	31/45	0.68
	7	6/9	8/9	6/9	9/9	9/9	38/45	0.84
D	1	5/9	6/9	5/9	6/9	5/9	28/45	0.62
	2	8/9	7/9	6/9	6/9	5/9	32/45	0.71
	3	5/9	7/9	5/9	6/9	6/9	29/45	0.64
	4	5/9	7/9	5/9	8/9	6/9	31/45	0.68
	5	7/9	8/9	7/9	4/9	5/9	31/45	0.68
	6	7/9	6/9	6/9	3/9	5/9	27/45	0.60
	7	1/9	3/9	3/9	6/9	6/9	19/45	0.42
E	1	8/9	7/9	6/9	7/9	6/9	35/45	0.77
	2	8/9	9/9	8/9	7/9	8/9	40/45	0.88
	3	8/9	8/9	5/9	7/9	8/9	36/45	0.80
	4	7/9	8/9	7/9	6/9	7/9	35/45	0.77
	5	8/9	8/9	6/9	3/9	7/9	32/45	0.71
	6	8/9	8/9	7/9	7/9	7/9	37/45	0.82
	7	7/9	6/9	7/9	6/9	7/9	33/45	0.73
Total score		242/315	265/315	232/315	258/315	262/315	1264/1575	
Consensus Index (Total score)		0.76	0.84	0.73	0.81	0.83	0.80	
Eligible item score		57/63	63/63	58/63	63/63	59/63	301/315	
Consensus Index (Eligible item)		0.90	1	0.92	1	0.94	0.96	

TABLE 1 · GAD-7

Consensus index by category and item (PHQ-9)

Table 2. Consensus Index about categories and items (PHQ-9)

Sign version	PHQ-9 items	Clarity	Comprehensibility	Semantic equivalence	Linguistic Naturalness	Non-Manual Components	Total score	Consensus Index
A	1	5/9	7/9	6/9	5/9	9/9	32/45	0.71
	2	8/9	8/9	9/9	7/9	7/9	39/45	0.86
	3	7/9	8/9	7/9	7/9	8/9	37/45	0.82
	4	8/9	9/9	9/9	6/9	9/9	41/45	0.91
	5	8/9	6/9	7/9	4/9	8/9	33/45	0.73
	6	4/9	7/9	5/9	7/9	7/9	30/45	0.66
	7	8/9	9/9	8/9	5/9	8/9	38/45	0.84
	8	8/9	7/9	7/9	6/9	8/9	36/45	0.80
	9	4/9	5/9	8/9	5/9	7/9	29/45	0.64
B	1	7/9	8/9	8/9	8/9	8/9	39/45	0.86
	2	8/9	8/9	8/9	9/9	8/9	41/45	0.91
	3	5/9	5/9	6/9	6/9	9/9	31/45	0.64
	4	8/9	9/9	9/9	9/9	9/9	44/45	0.97
	5	7/9	9/9	9/9	7/9	8/9	40/45	0.88
	6	7/9	8/9	6/9	7/9	8/9	36/45	0.80
	7	8/9	9/9	8/9	8/9	8/9	41/45	0.91
	8	4/9	5/9	5/9	6/9	7/9	27/45	0.60
	9	5/9	6/9	6/9	7/9	7/9	31/45	0.64
C	1	8/9	8/9	7/9	9/9	8/9	40/45	0.88
	2	6/9	8/9	3/9	8/9	7/9	32/45	0.71
	3	7/9	9/9	7/9	9/9	8/9	40/45	0.88
	4	8/9	9/9	9/9	8/9	8/9	42/45	0.93
	5	7/9	9/9	8/9	9/9	8/9	41/45	0.91
	6	4/9	7/9	1/9	9/9	8/9	29/45	0.64
	7	8/9	9/9	7/9	9/9	8/9	41/45	0.91
	8	5/9	6/9	7/9	9/9	8/9	35/45	0.77
	9	7/9	7/9	4/9	9/9	7/9	34/45	0.75
D	1	5/9	5/9	6/9	5/9	3/9	24/45	0.53
	2	4/9	3/9	4/9	7/9	5/9	23/45	0.51
	3	2/9	3/9	4/9	4/9	6/9	19/45	0.42
	4	6/9	6/9	8/9	7/9	7/9	34/45	0.75
	5	7/9	8/9	8/9	9/9	7/9	39/45	0.86
	6	6/9	7/9	6/9	5/9	5/9	29/45	0.64
	7	7/9	7/9	1/9	6/9	7/9	28/45	0.62
	8	4/9	6/9	6/9	3/9	5/9	24/45	0.53
	9	6/9	7/9	2/9	8/9	7/9	30/45	0.66
E	1	5/9	7/9	5/9	9/9	8/9	34/45	0.75
	2	5/9	7/9	5/9	8/9	7/9	32/45	0.71
	3	4/9	6/9	3/9	4/9	6/9	23/45	0.51
	4	8/9	9/9	8/9	8/9	8/9	41/45	0.91
	5	6/9	9/9	5/9	9/9	8/9	37/45	0.82
	6	7/9	7/9	7/9	7/9	8/9	36/45	0.80
	7	7/9	7/9	7/9	4/9	8/9	33/45	0.73
	8	7/9	6/9	7/9	3/9	8/9	31/45	0.64
	9	8/9	6/9	7/9	7/9	8/9	36/45	0.80
Total score		284/405	320/405	284/405	311/405	334/405	1532/2025	
Consensus Index (Total score)		0.70	0.79	0.70	0.77	0.82	0.76	
Eligible item score		69/81	72/81	68/81	73/81	73/81	355/405	
Consensus Index (eligible item)		0.85	0.89	0.84	0.90	0.90	0.88	

TABLE 2 · PHQ-9

Panel appropriateness ratings and LIS version accuracy

PANEL MEMBERS	GAD-7 ITEMS																																		TOTAL "YES" RESPONSES								
	A							B							C							D							E														
1	5	4	5	5	5	5	5	4	4	4	5	5	5	5	3	4	5	4	5	3	5	4	4	5	5	5	5	5	4	5	5	5	3	5	5	160							
2	5	4	4	5	4	2	3	5	5	5	5	5	4	4	5	4	2	5	5	5	3	5	4	5	4	4	3	1	3	4	5	5	4	4	4	2	140						
3	4	4	5	5	3	5	4	4	5	5	4	4	5	4	1	4	5	4	3	4	2	5	4	4	4	5	4	5	5	5	3	5	5	3	5	4	146						
4	5	4	5	5	4	5	5	5	5	5	5	5	5	4	4	4	5	5	5	4	4	5	4	2	3	3	4	1	5	5	5	3	5	5	5	153							
5	5	5	5	5	5	5	5	5	5	5	4	5	5	5	2	3	2	5	3	5	2	2	5	5	5	5	5	5	5	2	5	5	5	4	5	5	153						
6	3	3	1	4	4	3	5	5	5	1	2	2	3	3	3	3	5	4	4	3	3	0	1	0	1	0	0	1	1	3	0	0	0	0	0	0	76						
7	5	4	5	5	5	3	5	5	5	5	5	4	5	5	4	4	5	5	5	5	4	5	4	5	4	5	5	4	2	5	5	5	5	5	5	163							
8	5	4	3	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	3	5	5	1	1	4	3	4	2	2	3	4	3	5	5	5	4	148						
9	4	3	3	5	4	3	5	5	5	4	4	5	5	5	3	4	3	4	5	4	5	2	2	2	1	2	3	3	1	2	3	4	3	3	3	3	121						
% OF "5" (PER ITEM)	56%	44%	56%	78%	78%	44%	78%	67%	67%	50%	33%	56%	44%	67%	22%	11%	56%	33%	22%	33%	33%	11%	11%	11%	11%	11%	11%	11%	22%	56%	56%	44%	44%	44%	22%								
% OF ≤ 2 (PER ITEM)	0%	0%	0%	0%	0%	22%	0%	0%	0%	0%	11%	0%	11%	0%	22%	56%	0%	0%	0%	22%	0%	33%	22%	11%	0%	11%	44%	78%	11%	0%	0%	0%	11%	0%	11%								
LEGEND (Overall Appropriateness Level) 5/5 YES Excellent 4/5 YES Good 3/5 YES Adequate ≤2/5 YES Poor LIS VERSION ACCURACY (% OF "5" GIVEN ON AVERAGE) More accurate A (56%)B (53%)E (47%)C (37%)D (24%)Less accurate																																											
PANEL MEMBERS	PHQ-9 ITEMS																																		TOTAL "YES" RESPONSES								
	A								B								C								D								E										
1	5	4	5	5	4	5	5	3	5	4	5	5	5	5	2	5	5	5	5	5	3	5	5	5	4	4	3	5	5	3	5	5	5	5	5	5	207						
2	5	5	4	5	4	2	4	2	5	3	3	5	4	4	1	1	5	4	5	4	5	3	5	2	4	2	3	2	5	5	5	4	4	3	3	5	2	4	4	4	2	171	
3	2	4	5	5	4	5	5	4	4	4	4	4	4	4	4	4	2	2	3	3	3	3	3	5	4	4	4	4	3	4	4	5	5	4	4	3	4	4	170				
4	5	4	5	5	5	5	5	5	5	5	5	4	5	5	4	5	5	5	5	4	5	5	5	4	3	4	5	4	3	4	5	5	4	4	5	4	5	5	200				
5	5	5	5	3	3	5	5	3	3	5	3	2	5	4	3	5	3	1	3	1	4	0	5	5	2	3	3	2	4	3	5	5	4	0	4	4	5	5	3	5	4	4	169
6	3	3	0	4	3	3	2	6	0	3	5	1	4	4	3	2	0	0	0	0	3	3	3	4	4	3	3	1	1	4	3	3	0	0	2	3	2	2	0	0	82		
7	5	5	3	4	5	4	5	5	4	5	5	3	5	5	5	5	5	5	5	5	5	5	5	5	4	3	2	4	5	4	5	4	4	4	3	2	5	5	4	5	205		
8	5	4	5	4	4	4	5	5	5	5	5	5	5	5	4	5	5	4	5	5	4	5	5	4	2	0	1	3	4	0	3	1	2	2	4	4	3	5	3	4	4	180	
9	2	3	3	4	3	3	4	2	3	5	4	5	5	3	5	5	5	4	3	5	3	5	3	3	4	3	5	1	2	3	4	2	3	4	4	3	3	3	4	149			
% OF "5" (PER ITEM)	44%	56%	56%	44%	22%	44%	56%	44%	44%	56%	33%	56%	44%	44%	22%	11%	33%	56%	44%	56%	56%	33%	56%	33%	56%	44%	22%	11%	44%	56%	56%	44%	44%	56%	22%	44%	11%	44%	44%	44%	22%	44%	
% OF ≤ 2 (PER ITEM)	22%	0%	0%	0%	11%	0%	0%	22%	11%	0%	0%	11%	22%	44%	22%	0%	11%	0%	0%	11%	11%	0%	0%	11%	22%	56%	78%	11%	0%	0%	2%	11%	22%	0%	47%	11%	11%	11%	44%	11%	11%		
LEGEND (Overall Appropriateness Level) 5/5 YES Excellent 4/5 YES Good 3/5 YES Adequate ≤2/5 YES Poor LIS VERSION ACCURACY (% OF "5" GIVEN ON AVERAGE) More accurate A (43%)C (46%)B (36%)E (33%)D (31%)Less accurate																																											

TABLE 3 · GAD-7 AND PHQ-9 ITEM RATINGS

Differential psychological determinants of vaccine hesitancy: The role of conspiracy beliefs and personality across trust and risk components

Alessandra Perra¹, Giulia Cossu¹, Vivianne Kovess-Masfety², Stefano Lorrai¹, Noemi Mereu^{1,3}, **Massimo Tusconi**^{1,4}, Giovanna Elisa Calabrò^{5,6}, Corrado De Vito⁷, Azzurra Massimi⁷, Anna Odone^{8,9}, Giacomo Pietro Vigezzi⁸, Walter Ricciardi¹⁰, Giuseppina Lo Moro¹¹, Roberta Siliquini^{11,12}, Fabrizio Bert¹¹, Mauro Giovanni Carta¹

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Background: Vaccine hesitancy (VH) is a multidimensional construct, yet it is often operationalized through aggregate indices. However, the role of psychological determinants, such as conspiracy beliefs and personality traits, and their specific relationships with VH remain insufficiently understood. This study examined whether vaccine-related conspiracy beliefs and personality traits show differential associations with two integral components of VH: lack of trust and risk perception.

Methods: A cross-sectional, nationally representative survey of 51,573 Italian adults using web-based and telephone interviews. Personality traits were assessed using the Big Five Inventory-10. VH was measured using the Adult Vaccine Hesitancy Scale and operationalized as two continuous subscales scores: lack of trust and risk perception. Vaccine-related conspiracy beliefs were assessed using the Vaccine Conspiracy Beliefs Scale (VCBS). Pearson correlations and linear regression models were used to examine the independent associations of VCBS and personality traits with each VH component, adjusting for gender and age.

Results: VCBS showed strong positive associations with both components of VH, with a larger effect on lack of trust ($\beta = 0.5901$) than on risk perception ($\beta = 0.5018$). Higher agreeableness ($\beta = -0.0725$; $\beta = -0.0505$) and conscientiousness ($\beta = -0.0250$; $\beta = -0.0498$) were associated with lower lack of trust and lower risk perception. In contrast, higher emotional stability was associated with greater lack of trust ($\beta = 0.0148$) but lower risk perception ($\beta = -0.0247$), whereas higher openness was associated with lower lack of trust ($\beta = -0.0213$) but slightly higher risk perception ($\beta = 0.0108$). Extraversion showed small and opposite associations across the two dimensions.

Conclusion: VH reflects distinct psychological mechanisms across its components. Conspiracy beliefs are primarily anchored in mistrust toward vaccines and health authorities rather than in risk concerns, a pattern that also emerges for emotional stability. In contrast, personality traits—particularly emotional stability and openness—show differentiated associations, indicating that some individuals are more hesitant due to distrust, whereas others are more sensitive to perceived risks. These findings highlight the need for vaccination strategies that target the specific psychological drivers underlying different forms of hesitancy.

Funding: NextGenerationEU funding PNRR-Emerging Infectious Diseases (PE00000007, INF-ACT).

Correlations and regression predicting risk perception

Table 1. Pearson correlations of Big Five personality traits and vaccine conspiracy beliefs with vaccine hesitancy dimensions

	Lack of trust	Risk perception	VCBS
Extraversion	0.031	-0.020	0.026
Agreeableness	-0.205	-0.164	-0.224
Conscientiousness	-0.099	-0.132	-0.107
Emotional stability	-0.080	-0.097	-0.112
Openness	-0.056	-0.040	-0.054
VCBS	0.614	0.487	—

Note. The table reports Pearson's correlations between Big Five personality traits, the subscales of the adapted Vaccine Hesitancy Scale (aVHS), and the Vaccine Conspiracy Beliefs Scale (VCBS). All correlations were statistically significant at $p < .001$. Personality traits were measured on a 1–5 scale, whereas the VCBS was measured on a 1–7 scale. The aVHS subscales were Lack of trust, ranging from 7 to 35, and Risk perception, ranging from 3 to 15.

TABLE 1 · PEARSON CORRELATIONS

Table 2. Multiple regression predicting risk perception (N = 51,573)

Predictor	B (SE)	t	p	β (standardized)
Extraversion	-0.0720 (0.0161)	-4.46	<.001	-0.0170
Agreeableness	-0.2031 (0.0167)	-12.19	<.001	-0.0505
Conscientiousness	-0.2001 (0.0165)	-12.13	<.001	-0.0498
Emotional stability	-0.0865 (0.0147)	-5.89	<.001	-0.0247
Openness	0.0420 (0.0149)	2.82	.005	0.0108
VCBS (average score)	0.9429 (0.0074)	127.18	<.001	0.5018
Female gender	0.2946 (0.0258)	11.42	<.001	0.0437
Age (30-44)	0.2187 (0.0438)	4.99	<.001	0.0262
Age (45-59)	0.2894 (0.0417)	6.93	<.001	0.0389
Age (60-74)	0.7389 (0.0443)	16.69	<.001	0.0902
Age (75+)	1.9069 (0.0480)	39.76	<.001	0.2005
Constant	6.7454 (0.1086)	62.11	<.001	—

Model statistics. $N = 51,573$; $F(11, 51,561) = 1794.89$; $R^2 = 0.2769$; Adj. $R^2 = 0.2767$; Root MSE = 2.8678.

Note. Big Five traits are measured on a 1–5 Likert scale. Gender was coded as male = 0 and female = 1. Age was included as a categorical variable, with participants aged 18–29 years as the reference group. Reported β are standardized coefficients

TABLE 2 · RISK PERCEPTION (N = 51,573)

Regression predicting lack of trust

Table 3. Multiple regression predicting Lack of trust (N = 51,573)

Predictor	B (SE)	t	p	β (standardized)
Extraversion	0.2273 (0.0327)	6.94	<.001	0.0244
Agreeableness	-0.6408 (0.0338)	-18.97	<.001	-0.0725
Conscientiousness	-0.2211 (0.0334)	-6.61	<.001	-0.0250
Emotional stability	0.1133 (0.0298)	3.80	<.001	0.0148
Openness	-0.1827 (0.0302)	-6.06	<.001	-0.0213
VCBS (average score)	2.4372 (0.0150)	162.12	<.001	0.5901
Female gender	0.0863 (0.0523)	1.65	.099	0.0058
Age (30-44)	0.7931 (0.0888)	8.93	<.001	0.0433
Age (45-59)	0.6829 (0.0846)	8.07	<.001	0.0417
Age (60-74)	0.4254 (0.0898)	4.74	<.001	0.0236
Age (75+)	0.2565 (0.0972)	2.64	.008	0.0123
Constant	9.4441 (0.2202)	42.89	<.001	

Model statistics. $N = 51,573$; $F(11, 51,561) = 2927.78$; $R^2 = 0.3845$; Adj. $R^2 = 0.3843$; Root MSE = 5.8148.

Note. Big Five traits are measured on a 1–5 Likert scale. Gender was coded as male = 0 and female = 1. Age was included as a categorical variable, with participants aged 18–29 years as the reference group. Reported β are standardized coefficients

TABLE 3 · LACK OF TRUST (N = 51,573)

Epigenetic biomarkers for coping with hyperenergy: A pilot study of CACNA1C methylation

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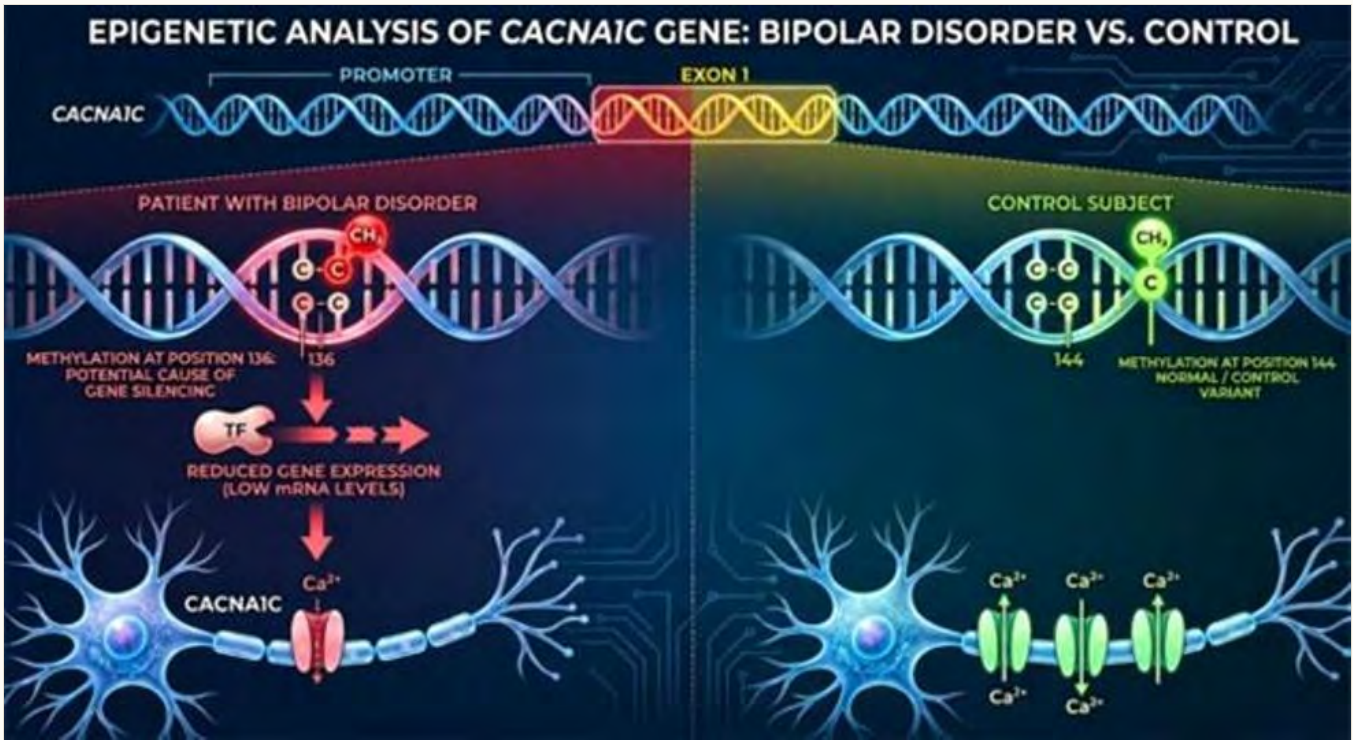
Introduction: The CACNA1C gene is one of the major genetic factors associated with bipolar disorder (BD). Recent evidence suggests that some of its variants may also be linked to behavioral traits such as hyperactivity and novelty seeking in otherwise without bipolar disorder. Nevertheless, the epigenetic mechanisms that may distinguish individuals with BD from those exhibiting hyperactive traits without psychopathological manifestations remain poorly understood. Therefore, the present study aims to investigate whether the methylation status of exon 1 of the CACNA1C gene can differentiate patients with bipolar disorder from hyperactive individuals who are well adapted to their environment, thereby contributing to the identification of potential epigenetic biomarkers of vulnerability to the disorder.

Methods: Nineteen carriers of the CACNA1C rs1006737 genetic variant were included in the study: 10 patients with BD and 9 individuals with adaptive hyperactivity. Participants were clinically assessed using the Mood Disorder Questionnaire (MDQ) and the Adaptive Hyperactivity and Goal Achievement scale (AGHA). Genomic DNA, automatically extracted from whole blood (QIAcube Connect MDx), underwent bisulfite conversion (EpiJET). The study focused on the CACNA1C gene, targeting the exon 1 region (NCBI NG_008801.2). The bioinformatic design of highly specific primer pairs using Methyl Primer Express v1.0 to distinguish methylated from unmethylated variants. The procedure concluded with Sanger sequencing to resolve the exact nucleotide sequence and map methylation sites.

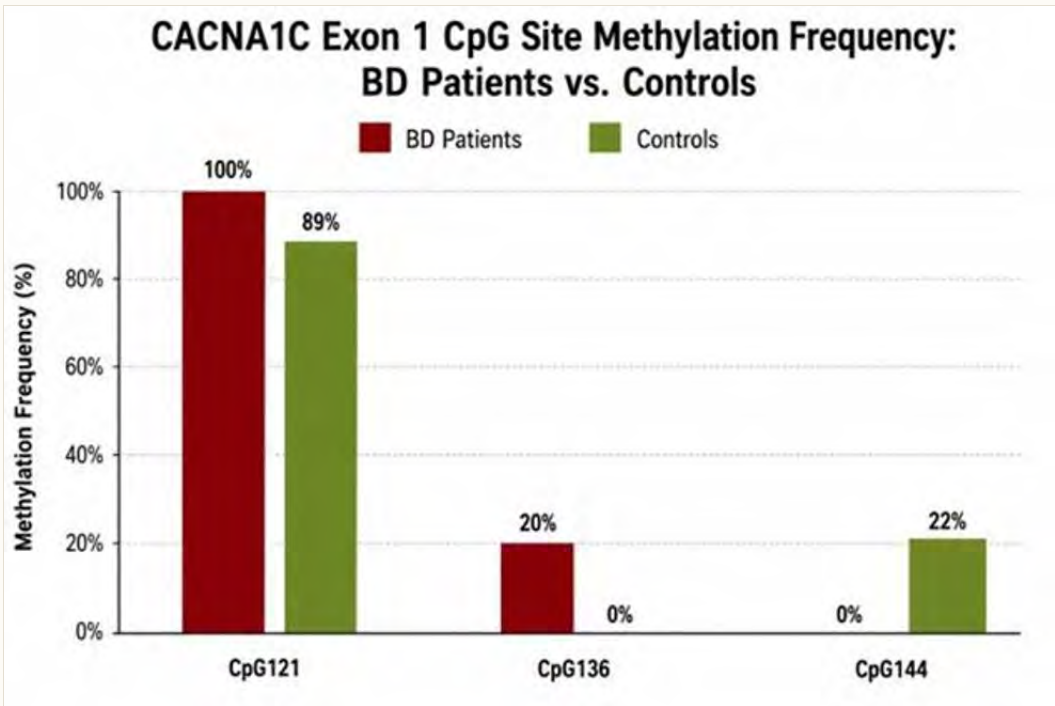
Results: Chromatogram analysis and sequence alignment revealed distinct methylation profiles between BD patients and controls. Within the targeted region, CpG sites 136 and 144 emerged as the most discriminative loci. Methylation at CpG136 was detected in 20% of patients and was absent in controls, whereas CpG144 methylation was observed exclusively in controls (22%). In contrast, CpG site 121 showed high methylation frequencies in both groups, specifically, in 100% of patients and 89% of controls.

Conclusions: This pilot study suggests differential DNA methylation patterns in CACNA1C between bipolar disorder patients and controls with adaptive hyperactivity, identifying CpG sites potentially associated with disease status. Although preliminary due to the small sample size, these findings support the potential role of epigenetic markers in bipolar disorder and highlight the need for validation in larger cohorts.

CACNA1C methylation: bipolar disorder versus control



IMG 1 · EPIGENETIC ANALYSIS OF CACNA1C



IMG 2 · CPG SITE METHYLATION FREQUENCY

From administrative flows to care pathways: Service-detected autism in ATS Pavia, Northern Italy, 2021-2025

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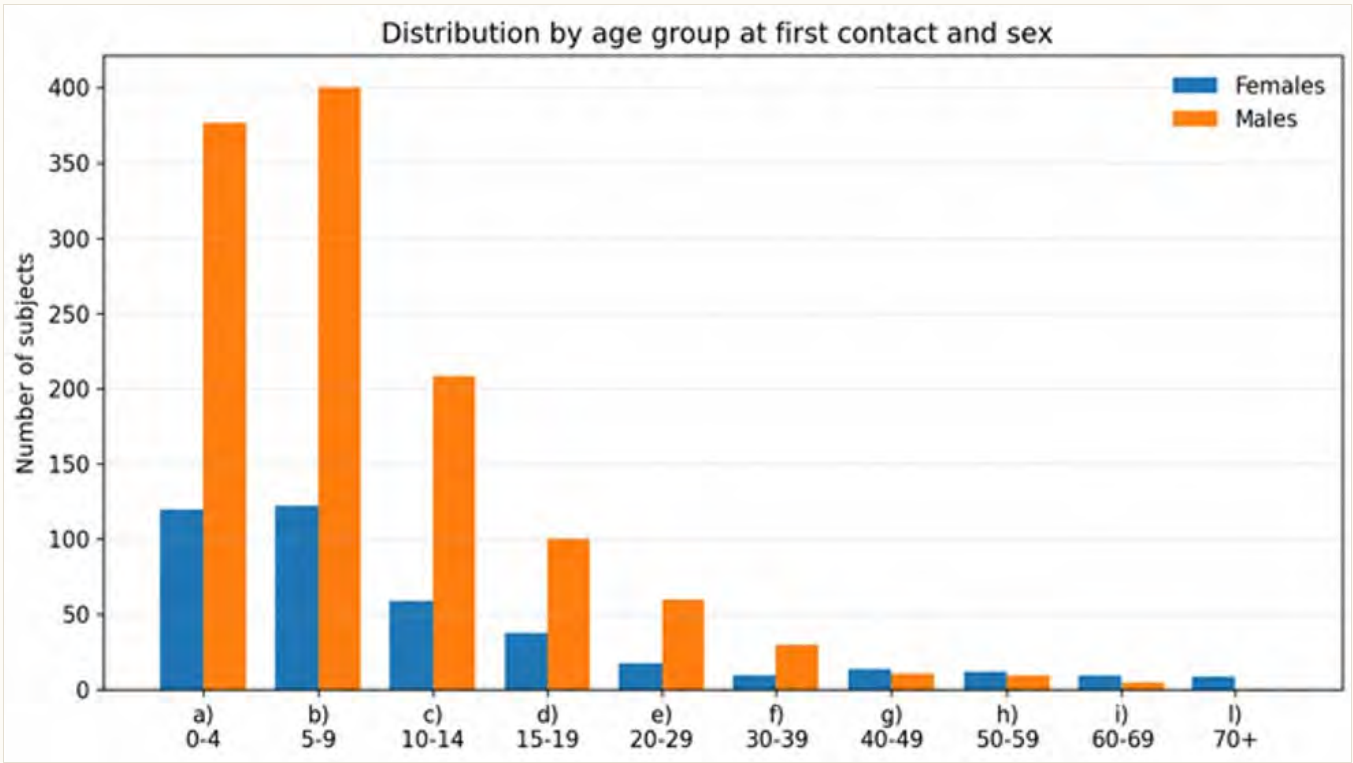
Introduction: Autism spectrum disorder (ASD) requires timely identification and continuity of care across childhood, adolescence and adulthood. ATS Pavia is the Local Health Agency responsible for public health governance and health and social-care planning in the Province of Pavia, Lombardy, Northern Italy. Within the Regional Autism Plan, ATS Pavia developed an administrative surveillance approach to quantify service-detected ASD and support pathway governance. We aimed to describe ASD cases identified through local administrative flows, focusing on age at first contact, source of identification, temporal trends and transition-age discontinuity.

Methods: We conducted a retrospective analysis of linked administrative health and social-care flows for 2021-2025. Case ascertainment used records from child neuropsychiatry, hospital discharge data, outpatient specialist care, rehabilitation, territorial services, adult psychiatry, and disability-related social care measures. For each person, the first available source was used as a proxy for the initial detection point. We distinguished subjects observed in the flows, subjects in care, incident-observed cases, and prevalent cases, and described distributions by sex, age, territorial area, identification source, and follow-up status.

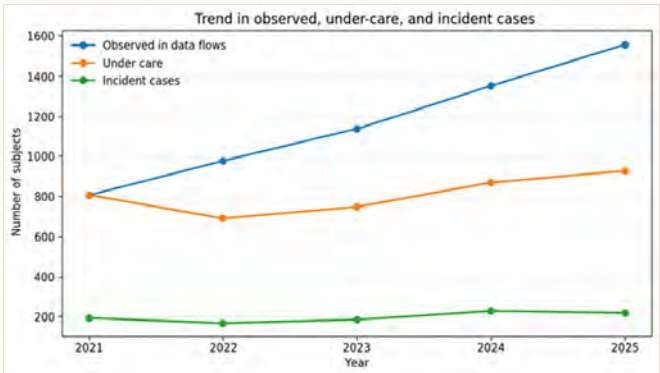
Results: Overall, 1,616 distinct subjects had at least one ASD-compatible record, corresponding to 5,846 person-year records. Most were male (n=1,203; 74.4%; Fig.1), and the median age at first observed contact was 7.0 years; 88.2% were identified before age 20. Child neuropsychiatry was the primary source of identification (n=1,011; 62.6%; 95% CI 60.2-64.9), followed by hospital discharge records (13.4%) and outpatient specialist care (6.8%). The number of subjects observed in the flows increased from 810 in 2021 to 1,561 in 2025, while the number of subjects classified as in care in 2025 was 930. Across the five years, 1,001 incident cases were identified (Fig.2). Females showed later first observed contact than males: 17.7% had first contact at age 20 years or older, compared with 9.7% of males (Fig.3). Among records aged 16-25 years, the proportion classified as lost to follow-up increased to 61.9% in 2025.

Conclusion: Administrative flows can inform local ASD surveillance and service planning, highlighting early detection through child neuropsychiatry but also possible late identification among females and adults, and administrative signals of discontinuity during the transition age.

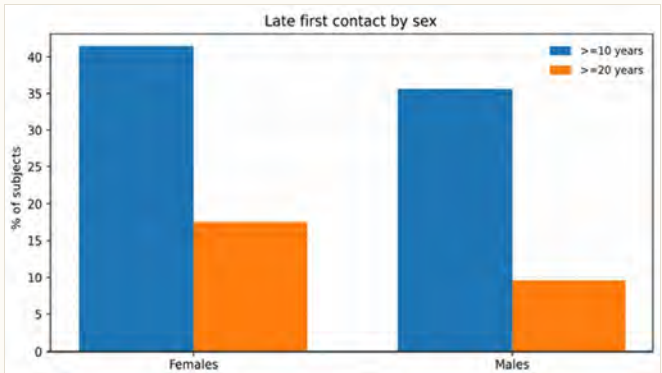
Service-detected autism in ATS Pavia, 2021-2025



IMG 1 · AGE GROUP AT FIRST CONTACT, BY SEX



IMG 2 · TREND 2021-2025



IMG 3 · LATE FIRST CONTACT BY SEX

From disability rights to local action: Development and validation of the PICI questionnaire for assessing perceptions of CRPD implementation in municipalities

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Introduction: Core principles of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), including participation, inclusion, accessibility, and non-discrimination, are increasingly recognized as determinants of mental well-being. Despite the adoption of the CRPD, persons with disabilities continue to face barriers across these domains, including discrimination, exclusion, restricted participation, inaccessible environments and information, and unequal access to opportunities and services, which are frequently associated with poorer health and mental health outcomes. Given the influence of local policies, services, and environments on these dimensions, evaluating the implementation of CRPD principles within municipalities through the perceptions of relevant stakeholders is particularly relevant. However, validated instruments designed for this purpose remain lacking. To address this gap, the Perceptions on the Implementation of the CRPD in municipalities Questionnaire (PICI-Q) was developed as the first stakeholder-reported instrument designed to assess CRPD implementation perceptions at the municipal level.

Methods: Following the identification of CRPD articles relevant to the municipal context, an initial 30-item questionnaire was developed and refined through a two-round Delphi process. After assessing face and content validity, the psychometric properties of the PICI-Q were evaluated in an Italian sample of 400 stakeholders (municipal policymakers and employees, persons with disabilities, family members, and representatives of organizations of persons with disabilities). The sample was randomly divided into two independent subsamples for Exploratory Factor Analysis (EFA; n=200) and Confirmatory Factor Analysis (CFA; n=200).

Results: Face and content validity were excellent (FVI=0.95; CVI=0.95). EFA supported a three-factor solution and reduced the initial 30-item questionnaire to a final 19-item instrument explaining 55% of the total variance. Three dimensions were interpreted as Institutional Support, Accessibility and Inclusion, and Protection from Discrimination. CFA confirmed the three-factor structure, showing acceptable fit (CFI=.983, TLI=.980, RMSEA=.082, SRMR=.071). Internal consistency was good across all dimensions (ordinal α =.80-.90).

Conclusions: The PICI-Q represents the first validated stakeholder-reported instrument designed to assess perceptions of CRPD implementation within municipalities. By operationalizing dimensions closely linked to participation, inclusion, accessibility, and non-discrimination, it provides an innovative tool for monitoring local implementation of disability rights, informing policy improvement and supporting equity and mental well-being through inclusive communities.

Exploratory factor analysis of the PICI-Q

Table 1 - Final Three-Factor Exploratory Factor Analysis Solution, Variance Explained, Factor Correlations, and Reliability Indices for the PICI-Q

Item number in the initial version of the PICI-Q	F1	F2	F3	h^2	Primary Factor
PICIQ_1	—	—	.822	.71	F3
PICIQ_2	—	—	.931	.84	F3
PICIQ_4	—	—	.659	.45	F3
PICIQ_5	—	.550	—	.43	F2
PICIQ_9	.845	—	—	.70	F1
PICIQ_10	.912	—	—	.77	F1
PICIQ_11	.513	—	—	.50	F1
PICIQ_13	—	.805	—	.57	F2
PICIQ_14	—	.558	—	.35	F2
PICIQ_16	.560	—	—	.50	F1
PICIQ_18	—	—	.401	.21	F3
PICIQ_19	.610	—	—	.47	F1
PICIQ_20	—	.704	—	.60	F2
PICIQ_21	—	.860	—	.66	F2
PICIQ_22	—	.658	—	.62	F2
PICIQ_24	—	.559	—	.40	F2
PICIQ_28	.531	—	—	.52	F1
PICIQ_29	.801	—	—	.65	F1
PICIQ_30	—	.527	—	.52	F2
Factor correlations					
F1-F2	.51				
F1-F3	-.36				
F2-F3	-.38				
Variance explained and factors reliability					
	Variance	% Variance explained	% cumulated variance	Ordinal reliability	Omega reliability
Factor 1 (7 items)	3.94	21%	21%	.898	.900
Factor 2 (8 items)	4.14	22%	43%	.887	.890
Factor 3 (4 items)	2.38	13%	55%	.802	.820

Note. Extraction method minimum residual (MINRES); rotation = Oblimin; factor loadings < .30 are suppressed; h^2 = communality.

TABLE 1 · FINAL THREE-FACTOR EFA SOLUTION

Confirmatory factor analysis of the PICI-Q

Table 2. Fit Indices

Model	χ^2	df	CFI	TLI	RMSEA	90% CI RMSEA	SRMR
Three-factor correlated model	350.51	149	.983	.980	.082	[.071, .094]	.071

TABLE 2 · FIT INDICES

Table 3. Standardized Factor Loadings for Three-factor correlated model, Standard Errors, z-values, R², and Reliability Indices for the Retained Three-Factor CFA Model

Item	Factor	Standardized Loading (λ)	SE	z	p	R ²
PICIQ_9	F1	.856	.041	20.88	< .001	.733
PICIQ_10	F1	.817	.046	17.76	< .001	.667
PICIQ_11	F1	.679	.061	11.13	< .001	.461
PICIQ_16	F1	.727	.056	12.98	< .001	.528
PICIQ_19	F1	.699	.059	11.85	< .001	.489
PICIQ_28	F1	.574	.073	7.86	< .001	.329
PICIQ_29	F1	.710	.058	12.24	< .001	.504
PICIQ_5	F2	.438	.083	5.28	< .001	.192
PICIQ_13	F2	.710	.057	12.46	< .001	.504
PICIQ_14	F2	.438	.082	5.34	< .001	.192
PICIQ_20	F2	.811	.045	18.02	< .001	.658
PICIQ_21	F2	.715	.057	12.54	< .001	.511
PICIQ_22	F2	.779	.049	15.90	< .001	.607
PICIQ_24	F2	.690	.060	11.50	< .001	.476
PICIQ_30	F2	.646	.065	9.94	< .001	.417
PICIQ_1	F3	.877	.036	24.36	< .001	.769
PICIQ_2	F3	.874	.037	23.62	< .001	.764
PICIQ_4	F3	.544	.076	7.16	< .001	.296
PICIQ_18	F3	.518	.080	6.48	< .001	.268

Note - CFA = Confirmatory Factor Analysis; λ = standardized factor loading; SE = standard error; z = critical ratio; R² = squared multiple correlation. F1 = Institutional Support; F2 = Accessibility and Inclusion; F3 = Protection from Discrimination.

TABLE 3 · STANDARDIZED FACTOR LOADINGS

Job satisfaction, human rights, and quality of care in mental health services: A scoping review

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Introduction: Improving healthcare quality is not only a clinical objective but a fundamental human right. Achieving rights-based care requires integrating the distinct, yet complementary perspectives of service users, professionals, and informal caregivers. This scoping review aimed to map the existing literature exploring how job satisfaction among mental health workers impacts: (RQ1) the perception of respect for human rights among professionals, patients, and caregivers; and (RQ2) the perception of the quality of care among patients and caregivers.

Method: Following PRISMA-ScR guidelines, a systematic search was conducted across major electronic databases (PubMed, Scopus, Web of Science, and EBSCO) to identify peer-reviewed quantitative, qualitative, and mixed-methods studies focusing on human rights frameworks in healthcare provision. Out of 348 results, eleven studies met the inclusion criteria and were included in the review.

Results: The quantitative literature mostly adopted cross-sectional design and relies almost exclusively on the Well-Being at Work and Respect for Human Rights Questionnaire. A highly consistent and cross-contextual finding is a perceptual asymmetry, where service users report more positive views on rights respect and care quality than professionals, while caregivers introduce a nuanced perspective, expressing higher organizational satisfaction but greater concerns over resources. Pervasive resource scarcity emerged as a universal barrier. Furthermore, qualitative evidence revealed that structural barriers (e.g., clinical stigma, lack of community inclusion) generate rights violations independently of individual attitudes.

Conclusion: Current literature is predominantly cross-sectional and mostly relies on self-report measures, limiting definitive causal inferences and risking social desirability bias. Future research should prioritise longitudinal designs and methodological triangulation, explicitly aligning subjective job satisfaction metrics with objective human rights benchmarks, in order to inform health policies.

Mental healthcare barriers, receipt of minimally adequate treatment, and associated healthcare costs across temporal patterns of anxiety and depression

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Introduction: One in three Canadians with a mental disorder reports unmet mental health care needs. To inform mental health service planning for timely access to quality mental health care, the objectives were to determine: (1) the prevalence of mental healthcare barriers and receipt of minimally adequate treatment (MAT) according to temporal patterns of moderate or severe symptoms of anxiety or depression (MSS-ANX-DEP); (2) the associated predisposing, enabling, and need factors; and (3) the health system costs associated with receipt of MAT in persistent and incident cases.

Methods: The study draws on data from the Ontario Health Study, one of the regional cohorts of CanPath. The sample includes 1374 participants who reported MSS-ANX-DEP (cutoff ≥ 10 on GAD-7 or PHQ-8) during the 2020 or 2021 surveys and consented to linking their health administrative data. Mental health service use (MHSU) since the pandemic was self-reported in 2021 and categorized as yes, no, did not feel the need, or no, due to barriers. MAT was defined as either ≥ 4 outpatient mental health physician encounters or ≥ 8 psychotherapy claims. Total healthcare system costs included inpatient, ambulatory, and drug expenses. Descriptive and multivariable regression analyses were carried out.

Results: Among the 24% of persistent cases not receiving MAT, 42% reported barriers to accessing MHSU, and 30% did not feel the need. Among the 13% of incident cases not receiving MAT, 32% reported barriers, and 45% did not feel the need to consult. The impact of anxiety/depression symptoms on daily activities rated as extremely/very difficult compared to somewhat or not at all, and the presence of multimorbidity, were associated with increased odds of receiving MAT; whereas socio-economic factors were not associated. The average healthcare cost associated with MAT in persistent cases was \$6,941 (95% CL: \$2,713, \$13,621).

Conclusion: Most individuals with anxiety or depression do not receive MAT, as defined primarily by medical encounters, and report barriers to accessing mental health services. Higher healthcare costs are associated with persistent, but not incident, cases, underscoring the importance of mental health policies that address barriers and improve the healthcare system's responsiveness to ensure timely access to quality mental healthcare.

Mindfulness-based interventions for psychological distress in chronic pulmonary diseases: Implications for integrated and global mental healthcare

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Introduction: Chronic pulmonary diseases (CPDs) are frequently associated with significant psychological burden, including anxiety, depression, disease-related stress, and reduced quality of life. These psychological factors may exacerbate symptom perception, impair self-management, and negatively affect overall health outcomes. Growing attention has therefore been directed toward integrated interventions capable of addressing both physical and mental health needs. Mindfulness-Based Interventions (MBIs) have emerged as promising approaches for enhancing emotional regulation, resilience, and adaptive coping in individuals living with chronic medical conditions.

Methods: A systematic review was conducted following PRISMA guidelines. PubMed, Scopus, and Web of Science were searched for studies published between 2005 and 2025 investigating the effects of mindfulness-based interventions in adults with chronic pulmonary diseases. Outcomes of interest included anxiety, depression, perceived stress, emotional functioning, illness-related distress, and health-related quality of life. Methodological quality was evaluated using established risk-of-bias assessment tools.

Results: Thirteen studies met the inclusion criteria, including eight randomized controlled trials and five observational or qualitative studies, involving approximately 1,080 participants with chronic pulmonary diseases. Across studies, MBIs were associated with meaningful improvements in psychological well-being. Significant reductions in anxiety, depressive symptoms, and perceived stress were consistently reported, alongside improvements in emotional regulation, self-compassion, psychological flexibility, and coping with illness-related challenges. Qualitative findings further highlighted greater acceptance of chronic illness, reduced catastrophic interpretations of symptoms, and increased engagement in meaningful daily activities. Improvements in health-related quality of life frequently accompanied these psychological benefits. Furthermore, digitally delivered mindfulness interventions demonstrated good feasibility and acceptability, suggesting their potential to increase access to psychological support among individuals facing geographical, physical, or healthcare-related barriers.

Conclusion: Mindfulness-based interventions appear to be feasible and potentially effective strategies for addressing psychological distress in individuals with chronic pulmonary diseases. By targeting transdiagnostic processes such as emotion regulation, resilience, acceptance, and adaptive coping, MBIs may contribute to more integrated and person-centered models of chronic disease management. The growing availability of digital delivery formats further supports their potential role within global mental health initiatives aimed at reducing disparities in access to evidence-based psychological care.

No-show prediction in ambulatory mental health services: A retrospective study and machine learning predictive pipeline

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Background: Non-presentation rates in mental health services range from 27% to 31% in published studies (Gajwani, 2014; Killiespie, 2000). Known predictors include age under 25, limited schooling, psychotic diagnoses, and substance use. The clinical and operational burden at Hôpital Montfort warranted both a descriptive analysis and the development of a predictive tool.

Objectives: To quantify no-show frequency and associated clinical characteristics, and to build and validate a machine learning (ML) pipeline predicting appointment non-attendance in ambulatory psychiatric care.

Methods: Electronic health records (January 2017–January 2022) covering 46,731 visits across 2,935 adult patients were analyzed. The ML pipeline tested five algorithms (XGBoost, CatBoost, LightGBM, RandomForest, Logistic Regression) at two analytical levels – individual visit and patient – using stratified 80/20 split, 5-fold cross-validation, and temporal validation (train 2017–2020, test 2021). Primary metric: F1-positive score.

Results: The overall no-show rate was 9.57%. In-person visits showed higher rates (10.49%) than e-visits (5.28%). No-shows were more frequent in men (11.04% vs. 8.42%), patients under 35 (44% of no-shows), and those diagnosed with Schizophrenia (48%). Post-COVID adoption of teleconsultation reduced the rate by 21% (10.31% → 8.17%). At the visit level, XGBoost achieved the best F1-positive score (0.322, ROC AUC = 0.750), but all models plateaued near AUC 0.72–0.75, indicating a structural informational ceiling. Patient-level aggregation yielded a marked improvement: XGBoost reached F1-positive = 0.606 (ROC AUC = 0.721), an 88% relative gain. CatBoost demonstrated superior ranking ability (AUC = 0.765). Temporal validation revealed systematic performance degradation at the visit level, likely reflecting pandemic-era distributional shifts. Notably, a six-variable heuristic score achieved AUC ≈ 0.70, only 0.02 points below the best ML model.

Conclusions: Teleconsultation substantially reduced no-shows and should be sustained for high-risk populations. Patient-level ML modelling significantly outperforms visit-level prediction. However, the marginal ML advantage over a simple heuristic tool raises important implementation considerations around interpretability and governance. Periodic model recalibration and prospective equity-disaggregated validation are recommended before clinical deployment.

Oral health and mental well-being: Targeting fusobacterium nucleatum with pistacia lentiscus essential oil

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Background: The Sardinian Blue Zone, particularly the region of Ogliastra, is recognized as a model for healthy longevity, distinguished by its remarkable concentration of centenarians. Oral health is increasingly viewed as a critical factor in healthy aging due to its links to systemic inflammation, cognitive function, and overall well-being. Emerging evidence indicates that dysbiosis of the oral microbiome may contribute to inflammatory pathways associated with age-related diseases and mood disorders, underscoring the necessity of preventive oral hygiene strategies. Ethnographic interviews with Sardinian centenarians have also highlighted the traditional use of *Pistacia lentiscus* chewing sticks for daily oral care. This is particularly relevant given the role of the oral pathogen bacterium *Fusobacterium nucleatum*¹ in promoting systemic inflammation, a known factor in depression.

Methods: The antimicrobial properties of *P. lentiscus* berry oil², and essential oil³ against *F. nucleatum* were assessed by using agar diffusion (Kirby-Bauer), minimum inhibitory concentration (MIC), minimum bactericidal concentration (MBC), and minimum biofilm inhibitory concentration (MBIC) assays. Additionally, cytotoxicity was evaluated on HT-29 human cells through the Cell Viability Assay (MTT).

Results: Berry oil showed no antimicrobial activity against *F. nucleatum* (MIC, MBC, and MBIC >50% v/v) and no cytotoxicity toward HT-29 cells. In contrast, the essential oil exhibited strong antibacterial and antibiofilm activity (20 mm inhibition zone; MIC and MBIC = 0.78% v/v; MBC = 1.56% v/v) and reduced HT-29 cell viability in a concentration-dependent manner. Interestingly, the presence of *F. nucleatum* partially or completely counteracted this cytotoxic effect, suggesting modulation of tumor cell survival pathways.

Conclusions: *Pistacia lentiscus* essential oil effectively inhibits *F. nucleatum*, providing experimental support for the potential benefits of traditional oral hygiene practices documented in the Sardinian Blue Zone. Modulation of the oral microbiome may represent one mechanism linking these ancestral practices to oral health and healthy aging. Further studies are warranted to confirm these findings and explore their clinical relevance.

References

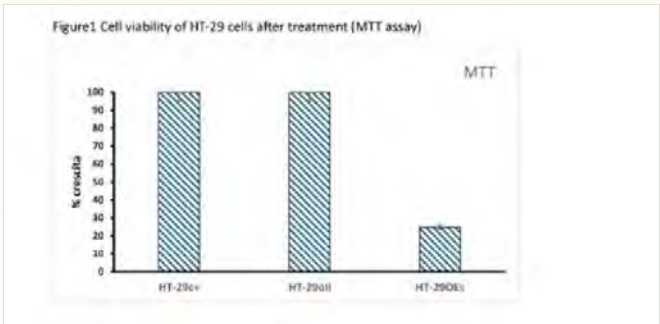
- 1) Singh Solorzano et al., PMID: PMC12274322.
- 2) Orrù et al., PMID: PMC5660700.
- 3) El-Mernissi et al., PMID: PMC12350941.

Antimicrobial activity and HT-29 cell viability

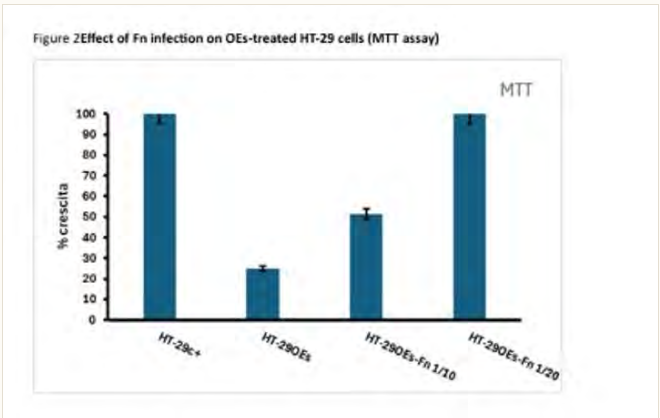
Table 1 – Antimicrobial of berry oil and essential oil

Parameter	Berry oil	Essential oil
Antimicrobial activity against <i>F. nucleatum</i>	No activity (MIC, MBC, MBIC > 50% v/v)	Strong antibacterial activity
Antibiofilm activity	None (MBIC > 50% v/v)	Present (MBIC = 0.78% v/v)
Inhibition zone	Not observed	20 mm
MIC	> 50% v/v	0.78% v/v
MBC	> 50% v/v	1.56% v/v
MBIC	> 50% v/v	0.78% v/v

TABLE 1 · ANTIMICROBIAL ACTIVITY OF BERRY OIL AND ESSENTIAL OIL



IMG 1 · HT-29 VIABILITY (MTT)



IMG 2 · EFFECT OF FN INFECTION

Patient outcomes of a pilot cluster randomized controlled feasibility trial of a lived experience-led model of psychosis care integrated across primary care, community, and home settings in Uganda

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Introduction: Mental health services are most effective and equitable when designed, delivered, and evaluated in collaboration with people with lived experience of mental illness. We aimed to evaluate outcomes of the “Strengthening Care in collaboration with People with lived Experience of psychosis in Uganda (SCAPE-U)” intervention on persons living with Psychosis and their caregivers.

Methods: We conducted a pilot cluster randomized controlled mixed-methods, feasibility trial in Uganda, comparing standard care where Primary Health providers (PHPs) were trained by mental health specialists, versus the intervention arm, where people with lived experience of psychosis (PWLP) were trained using PhotoVoice and engaged as facilitators in PHP training, early identification, and home based support for service users and their caregivers. The main quantitative outcome was change in psychosis symptoms on the Positive and Negative Symptom Scale (PANSS) at baseline, month 4, and month 8 within each arm. Additional outcomes for persons accessing psychosis care at primary care included quality of life, (QOL) experienced stigma and social inclusion.

Results: A total of 60 service users were enrolled (30 per arm). Participants were predominantly female (56.7%) with a median age of 38 years (IQR 29–49). Overall, substantial improvements in PANSS scores were observed by month 4 in both study arms, with only marginal additional change thereafter. There were modest improvements in QOL in both groups, followed by stabilization, with no clear or sustained advantage of SCAPE U over standard care. SCAPE U produced a significantly greater reduction in caregiver burden by month 8.

Conclusion: Both study arms produced some improvements in psychosis symptoms, QOL, and family reported outcomes over the 8-month follow-up, with the greatest gains occurring by month 4 and no or minimal additional gain thereafter. While SCAPE U did not outperform standard care on psychosis related or QOL outcomes, it conferred a notable and statistically significant reduction in caregiver burden, an important dimension of treatment impact. Although between arm differences in clinical outcomes were not statistically significant, the results highlight the value of integrating PWLP into primary care-led psychosis care in Uganda.

Source of Funding: Wellcome Trust UK

Predicting repeated self-harm in university students: Toward early identification and prevention

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Introduction: Self-harm behaviors are significant mental health concerns frequently encountered during adolescence and early adulthood, particularly among university students. However, research on prediction models for repeated self-harm in this population remains limited. Therefore, this study aimed to develop a clinical scoring system to predict repeated self-harm within 6 months among university students.

Methods: A retrospective cohort study was conducted among university students presenting with self-harm at two university hospitals in Thailand. Cox's proportional hazard regression was used to develop the prediction model. Internal validation was performed using bootstrap resampling.

Results: Among 134 university students presenting with self-harm, 45.5% repeated self-harm within 6 months. Five clinical predictors were identified and incorporated into the prediction model: age at onset of psychiatric illness, psychotic depression, borderline personality disorder, bipolar disorder, and family conflict. The model demonstrated acceptable discrimination (AuROC = 74.4%, 95% CI: 68.4%–80.4%) and good calibration after bootstrap internal validation.

Conclusion: The proposed prediction model may facilitate early identification of university students at high risk for repeated self-harm and support targeted preventive interventions.

Keyword: Self-Injurious Behavior, Recurrence, Clinical Decision Rules, Students, Early diagnosis

Psychotherapy dose response among community-dwelling elder abuse victims experiencing depression

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Introduction: Elder abuse affects approximately 10% of older adults in the United States and is associated with twice the burden of mental health disorders compared to non-abused peers. Although evidence-based interventions are available, little is known about the timing of treatment response among elder abuse victims. This study examined the proportion of participants who achieved treatment response, time required to respond, and demographic and abuse-related factors associated with variation in time-to-response.

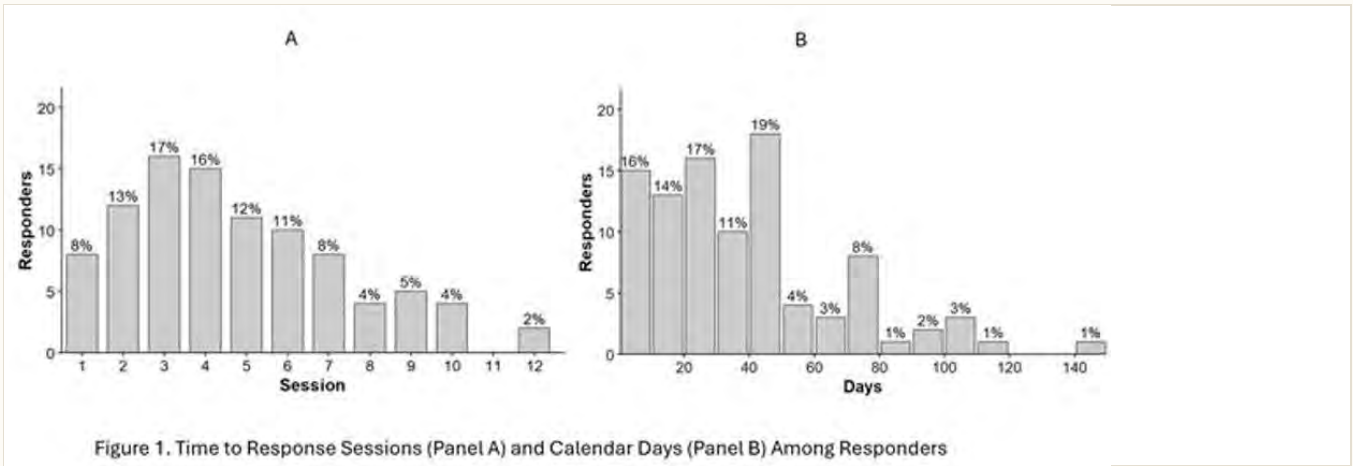
Methods: The study included 128 elder abuse victims (91% Female, 45% White) referred from collaborating agencies to the PROviding Options To Elderly Clients Together (PROTECT) program in New York City between 2018 and 2022. Adults aged ≥55 years who experienced elder abuse and screened positive for clinically significant depressive symptoms (PHQ-9 ≥10) were offered no-cost psychotherapy services. Time-to-response was evaluated using Kaplan-Meier survival analyses and Cox proportional hazards regression models, with treatment duration measured by both psychotherapy sessions attended and calendar days in treatment. Response was defined as a ≥50% reduction in PHQ-9 score from baseline.

Results: Overall, 74.2% of participants achieved treatment response by their final session. Among responders, approximately one-fifth responded within the first two psychotherapy sessions or within 10 days of treatment initiation. The median time-to-response was six sessions or 42 days. In adjusted Cox proportional hazards models, Black participants achieved a faster treatment response compared to White participants when treatment duration was measured by sessions (HR=1.84 95% CI [1.09-3.11], p=.02) but not calendar days (HR=1.50 95% CI [0.89-2.52], p=.13). Non-Hispanic participants had a marginally slower response compared to Hispanic participants when treatment duration was measured by sessions (HR=0.62 95% CI [0.36-1.06], p=.08) but not calendar days (HR=0.70 95% CI [0.41-1.19], p=.19). Age, sex, and abuse characteristics (polyvictimization, multiple perpetrators, perpetrator currently in home) were not significantly associated with time-to-response.

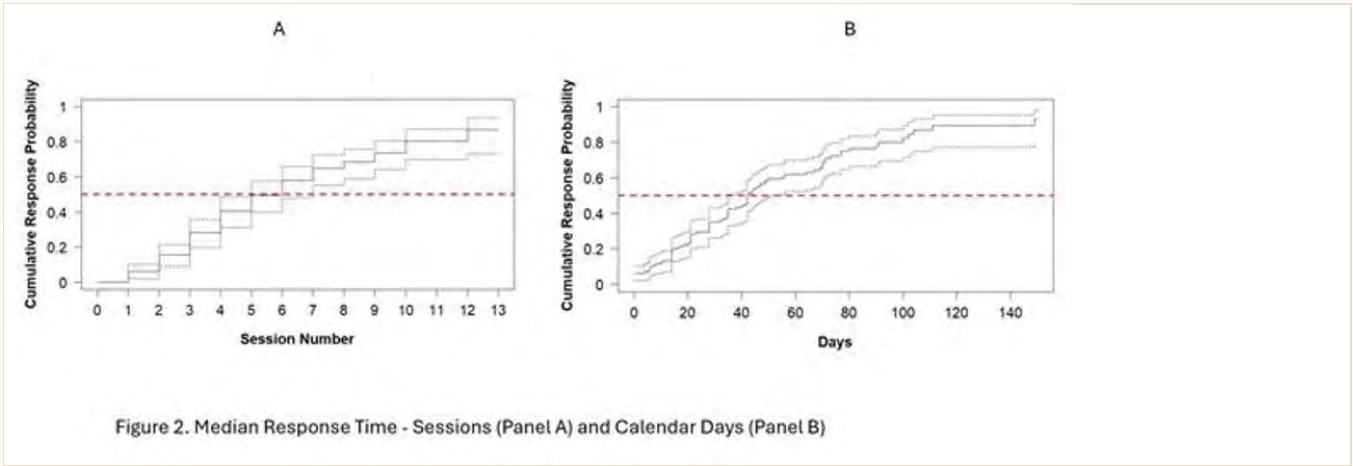
Conclusions: To our knowledge, this is the first study to examine treatment dose-response patterns among a community-based sample of elder abuse victims receiving psychotherapy for depression. Our findings underscore that accessible, evidence-based mental health care among older victims may result in a clinically meaningful depression response early in treatment, particularly for marginalized groups.

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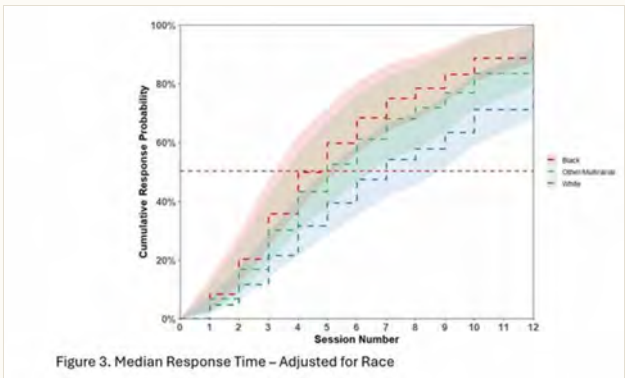
Time to response among responders



IMG 1 · SESSIONS AND CALENDAR DAYS



IMG 2 · MEDIAN RESPONSE TIME



IMG 3 · ADJUSTED FOR RACE

Psychosocial and sociodemographic predictors of APOE testing uptake among Latino adults

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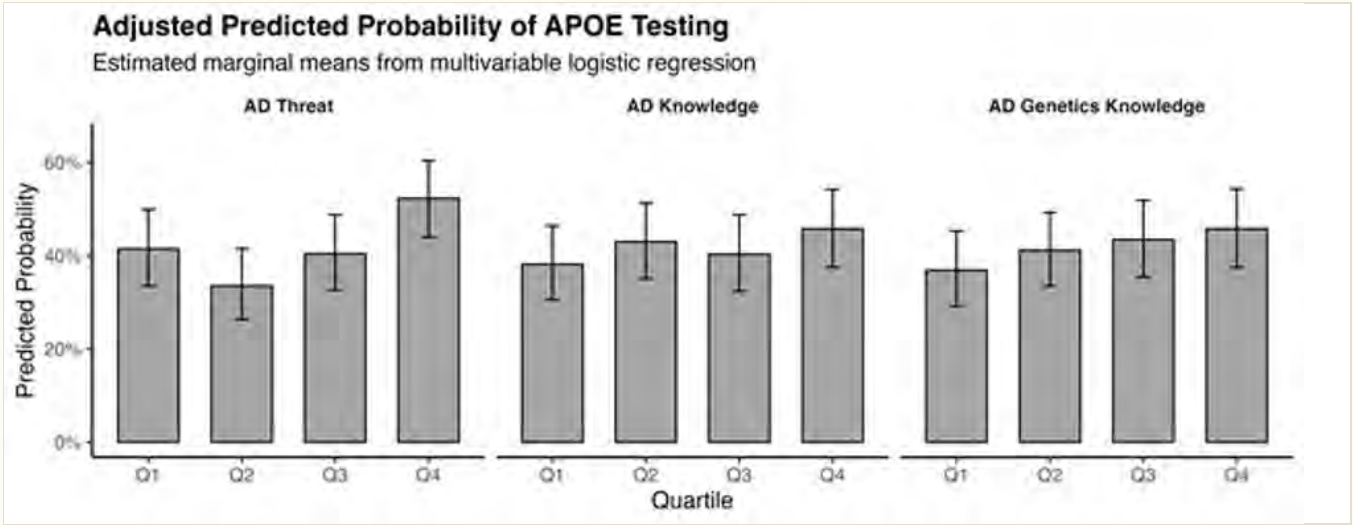
Introduction: Latinos are disproportionately affected by Alzheimer's disease (AD) in the US. Genetic testing for AD marker apolipoprotein E gene (APOE) may help Latinos understand their risk and motivate risk-reducing lifestyle changes. However, little is known about psychosocial and sociodemographic predictors of APOE testing uptake, including perceived AD threat, AD knowledge, and AD genetics knowledge, among Latino adults. We examined these predictors in a randomized controlled trial.

Methods: We analyzed data from 2,087 baseline survey participants from northern Manhattan (mean age 52, 71% women, 40% college graduates). Primary analyses used multivariable logistic regression to examine whether sociodemographic characteristics, perceived AD threat, AD knowledge, and AD genetics knowledge were associated with APOE testing uptake. Secondary analyses used survey-weighted linear regression to examine sociodemographic correlates of AD threat, AD knowledge, and AD genetics knowledge. All models adjusted for preferred language, age, gender, education, Latino national origin subgroup, employment, religion, insurance, marital status, and family history. APOE models additionally included quartiles of perceived AD threat, AD knowledge, and AD genetics knowledge.

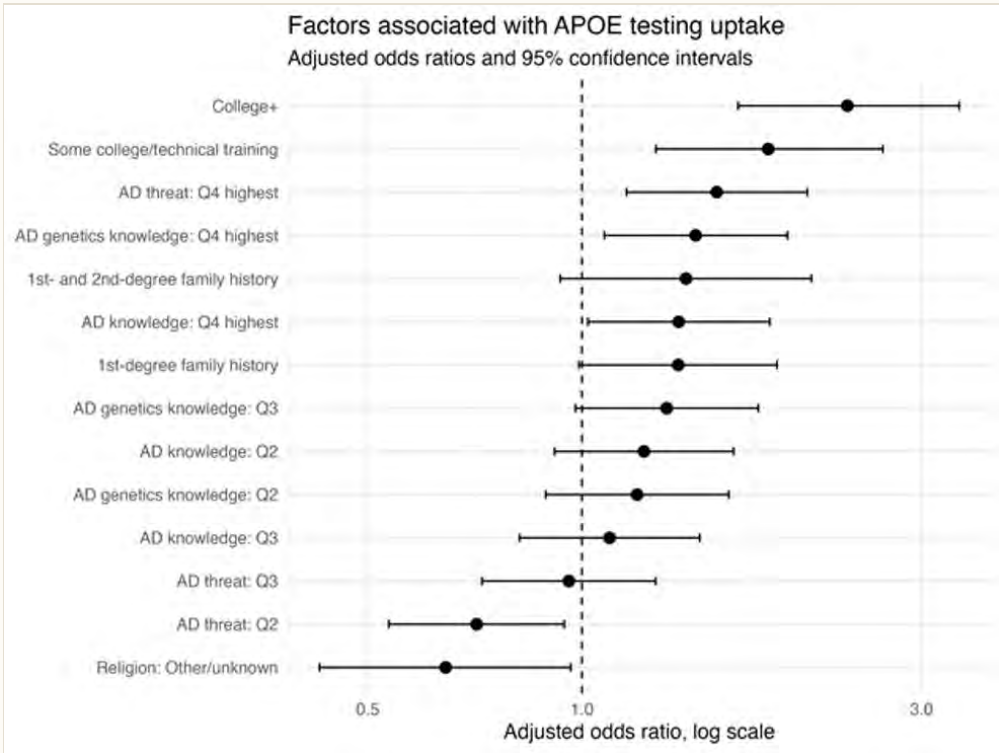
Results: Higher educational attainment was associated with APOE testing uptake. Compared with participants with less than high school education, those with some college/technical training had higher odds of testing (OR=1.83, 95% CI: 1.27-2.65), as did those with college or higher education (OR=2.36, 95% CI: 1.66-3.39). Participants in the highest AD threat quartile had higher odds of testing than those in the lowest quartile (OR=1.55, 95% CI: 1.15-2.07). Highest-quartile AD knowledge (OR=1.37, 95% CI: 1.02-1.84) and AD genetics knowledge (OR=1.44, 95% CI: 1.07-1.94) were also associated with testing uptake. Secondary analyses showed that Spanish-preferring participants and those with a family history of AD had higher perceived AD threat, which was associated with greater AD genetics knowledge.

Conclusion: APOE testing uptake was associated with education, perceived AD threat, AD knowledge, and AD genetics knowledge. Linguistically tailored educational strategies that improve AD knowledge and address AD risk perception may increase participation in community-based AD genetic testing and reduce disparities among Latino adults.

APOE testing uptake among Latino adults



IMG 1 · ADJUSTED PREDICTED PROBABILITY



IMG 2 · ADJUSTED ODDS RATIOS

Strengthening specialized capacity in Greek public services through the co-development and implementation of psychotherapeutic protocols for child and adolescent mental health conditions

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Introduction: Despite evidence supporting child and adolescent cognitive behavioural therapy (CBT) globally, interventions remain largely unavailable within public systems. This gap requires implementation models integrating development, training, and scalability research within real-world settings and changes in management structures. Here we developed and implemented manualised psychotherapeutic protocols through a national capacity-building initiative in Greece.

Methods: This study was conducted through the Child and Adolescent Mental Health Initiative (CAMHI), a nationwide public-private partnership involving clinical and academic institutions across Greece. We designed a structured implementation pathway operationalizing the integrated framework introduced by the 2024 Lancet Psychiatry Commission on Transforming Mental Health Implementation Research: (1) pre-implementation research through national reviews and national surveys of health professionals; (2) co-development and iterative pilot implementation of evidence-based interventions through supervised practice within the National Health System; and (3) dissemination research supporting scalability and institutionalisation within public structures.

Results: Pre-implementation research identified gaps in the availability of clinical protocols in Greek services; a survey of 120 psychologists and psychiatrists indicated the need for psychotherapeutic training. Three evidence-based protocols were co-developed: CBT for anxiety (6–12 years), CBT for depression (12–17 years), and behavioural parent training (BPT) for disruptive behaviour (4–14 years). During a three-stage pilot, 45 clinicians delivered interventions to 140 cases (anxiety n=52; depression n=25; BPT n=63); 117 (83.5%) completed treatment. Significant symptom reductions were observed for anxiety ($d=-2.92$; RCADS-25), depression ($d=-1.79$, RCADS-25), and disruptive behaviour ($d=-2.3$, SNAP-IV), with 63%, 38% and 44% showing reliable improvement at the treatment endpoint. A train-the-trainer model is under implementation for national scale-up. Institutionalisation includes integration into child and adolescent psychiatry curricula. Sustainability safeguards were established through Law 5015/2023, with the Ministry of Health assuming operations by 2027.

Conclusion: Pilot results demonstrate the feasibility of evidence-based psychotherapeutic interventions embedded within real-world child and adolescent services in Greece. Integrated implementation approaches provide a viable pathway for developing, refining, and scaling clinical manuals within public health provision.

Funding: The CAMHI is exclusively supported by the Stavros Niarchos Foundation.

Strengthening the public health management cadres to mitigate over-burdening and promoting mental wellbeing of the frontline health workers, the backbone of an effective operative primary health care system in India

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Introduction: Ever since the launch of National Health Mission (NHM) in 2005, the roles of frontline health workers (FWWs) in Indian public health system have been invaluable. The National Health Programs (NHPs) have been frequently revised to align them with the changing health care needs and priorities and Sustainable Development Goals (SDGs) for 2030, alongside the introduction of novel digital health initiatives under the Ayushman Bharat Digital Mission. The objective of our study was to define job duties of supervisory cadres at Primary Health Centre (PHC) to understand grassroot level workload of various staff, considering major changes witnessed over the last few decades in response to the ever-increasing healthcare demands and disease burden.

Methods: An MoU was executed between Institute of Public Health Sciences, Hyderabad and Department of Health, Medical and Family Welfare- Government of Andhra Pradesh (AP) in January 2024. We conducted qualitative study using methodological triangulation approach. A preliminary documentary analysis was carried out through desk-based review, that was followed by key informant research from In-depth interviews lasting 30-45 minutes after participants consent. We adopted thematic analysis using grounded theory to map the roles and responsibilities of various cadres of a functional PHC in AP state.

Results: Our study results revealed that FWWs, particularly Auxiliary Nurse Midwife (ANM) are getting overburdened, with various program implementation relying heavily on their efforts. As a final step to carrying out various activities, these frontline health workers need to extensively document their work, by both manual means and digital record-keeping. A recent notable addition is to secure national quality assurance standards (NQAS) accreditation by the sub-centers to ensure quality services through these facilities.

Conclusion: The data reported from various programs are unquestionably important for policy decisions and resource allocation. However, the capacity of these health workers in balancing their abilities and workload is unfortunately one of the most often ignored aspects within the primary health care delivery. It is suggested to critically explore options of task shifting; keeping in mind the health workers wellbeing for efficient execution of PHC services.

Keywords: Community Health Workers; Health Workforce wellness; Health Services Accessibility

Testing the diagnostic expansion hypothesis with a population-based survey of attitudes to depression in Australia

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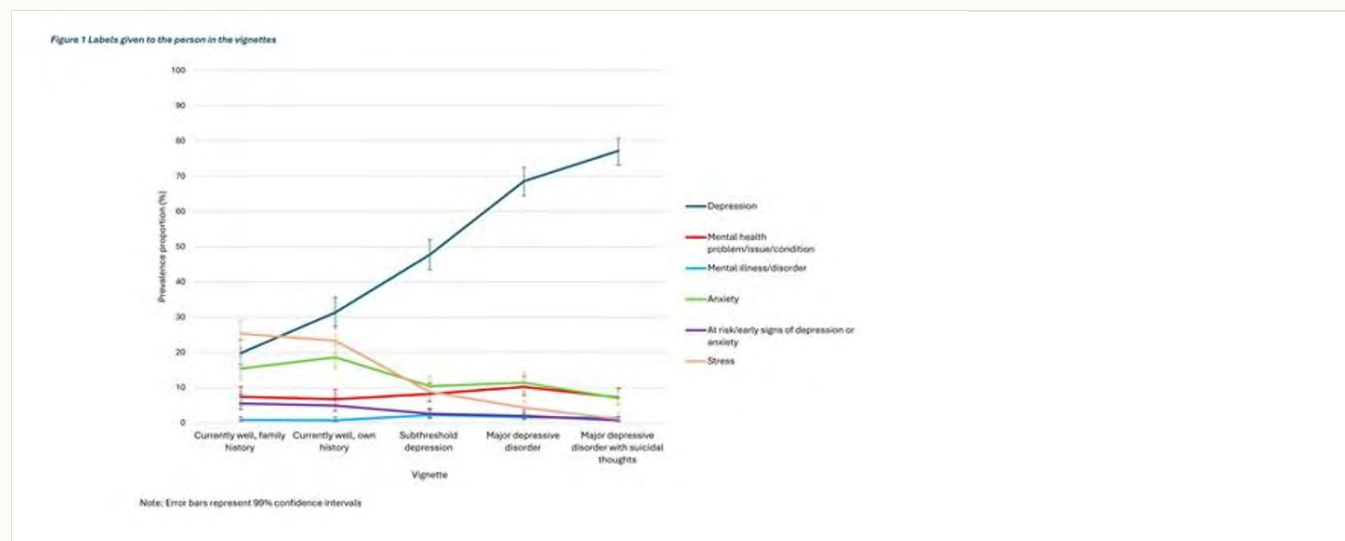
Introduction: There is growing concern about the increasing use of psychiatric terminology to describe behaviors and experiences that do not meet criteria for diagnosis of a mental illness. We aimed to conduct a nationally representative online cross-sectional survey exploring diagnostic labelling of vignettes describing a person with different levels of depression symptoms or risk and whether this was associated with mental health-related intended actions and psychological distress.

Methods: Australian respondents (n=6042) were randomly assigned to read one of five vignettes describing a person in the following situations: (1) Currently well (family history of depression); (2) Currently well (own history of depression); (3) Subthreshold depressive symptoms; (4) Major depressive disorder (MDD); and (5) MDD with suicidal thoughts. They were asked what, if anything, was wrong with this person. Further questions covered intentions to seek professional help or take self-help actions; psychological distress and personal experience of depression.

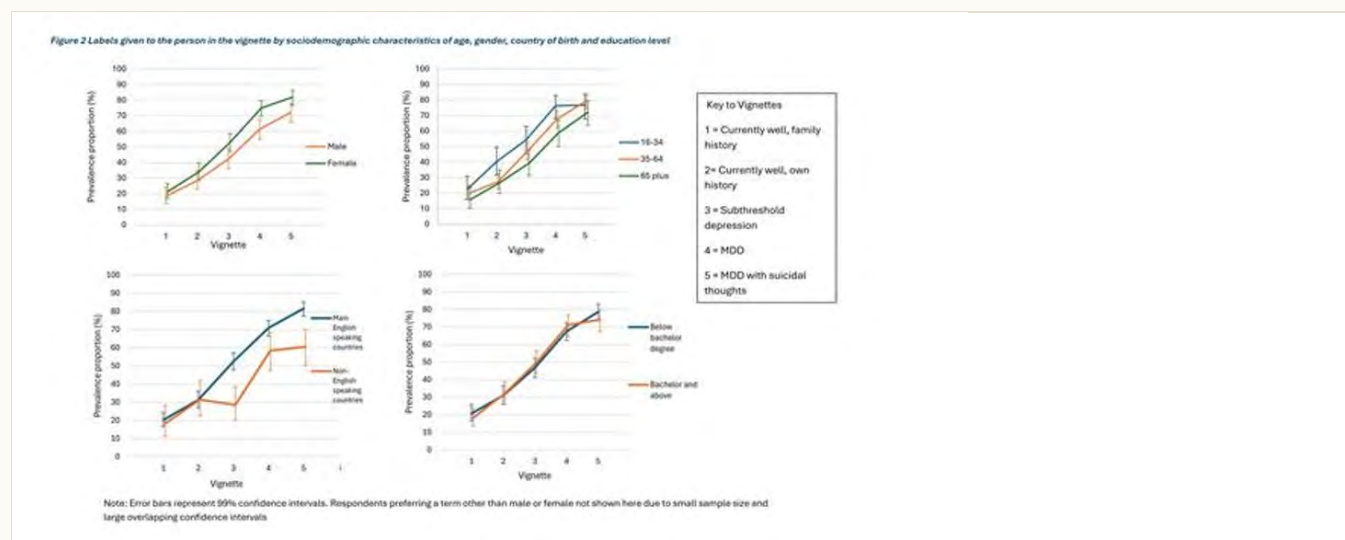
Results: Labelling non-clinical or subthreshold vignettes with diagnostic labels was relatively common, with a depression label applied by 19.8% [99%CI 16.6,23.6], 31.3% [99%CI 27.4,35.6], 47.7% [99%CI 43.4,52.0], 68.6 [99%CI 64.5,72.5] and 77.2 [99%CI 73.1,80.7] of respondents to vignettes 1 to 5 respectively. Younger people were more likely to give a depression label. Across all vignettes, labelling was associated with a greater likelihood of intentions to speak to a health professional or take medication but not with psychological distress or reductions in effective self-help.

Conclusion: Findings suggest that public messages should have a more nuanced approach, making it clear that for some mental health difficulties, non-medical solutions may be more appropriate, while also taking care not to increase the proportion of people with more severe problems who meet diagnostic criteria but do not seek help.

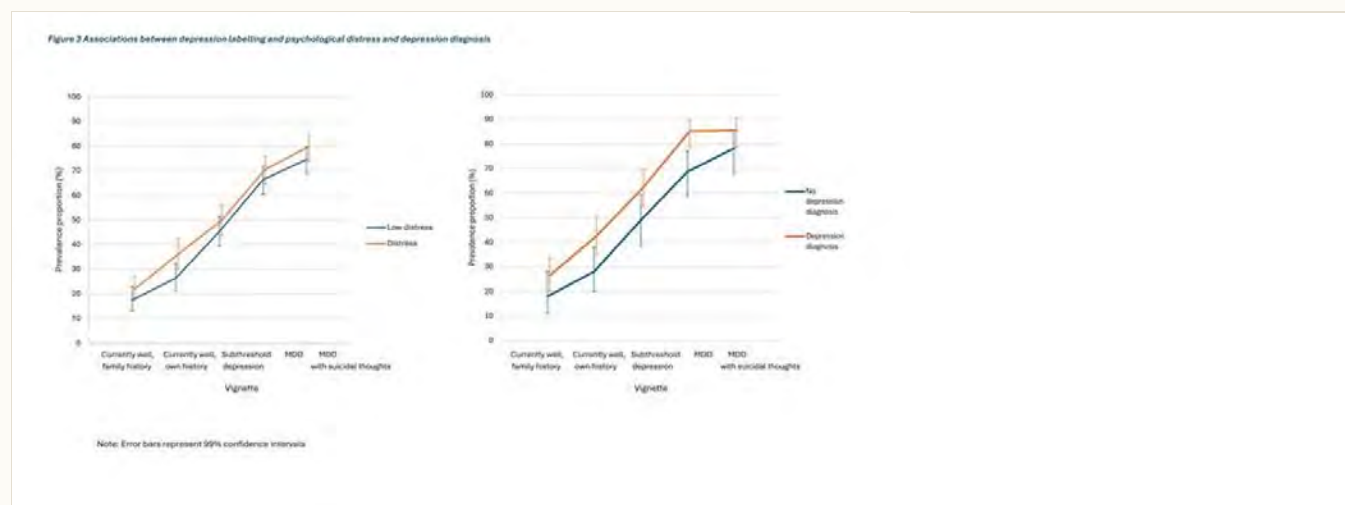
Labels given to the person in the vignettes



IMG 1 · LABELS BY VIGNETTE



IMG 2 · BY SOCIODEMOGRAPHIC CHARACTERISTICS



IMG 3 · DISTRESS AND DIAGNOSIS

The language of numbers: Translation and comparability in the epidemic of common mental disorders in Brazil

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Recently, The Lancet published estimates pointing to a significant increase in the prevalence and burden of mental disorders worldwide. The resulting picture of an expanding epidemic of common mental disorders has become increasingly difficult to question. However, little scholarship has examined how these numbers come into being. Based on a science ethnography examining how a multidisciplinary team translated the CIDI 5.0 into Brazilian Portuguese between September 2024 and February 2025, in dialogue with reflections produced in the Sapopemba favela, on the eastern periphery of São Paulo, regarding categories of common mental disorders, we ask: can epidemiology and clinical practice speak the same language? If not, in what ways do the worlds they assemble nevertheless produce the unity required for diagnosis and comparability? With these questions, we rethink epidemiological numbers beyond the objectivity they appear to possess, tracing the relations, negotiations, and practices of translation that remain hidden beneath their quantifiable surface. We argue that epidemiological categories operate as translation devices that produce provisional equivalences among heterogeneous experiences of suffering by transforming subjective differences into numerical distinctions through scales, frequencies, durations, and diagnostic thresholds. In this sense, numbers participate in the production of a common language through which experiences of suffering become comparable. Is this a genuinely multicultural language capable of accommodating different worlds of experience, or a particular form of equivalence produced through translation itself? By investigating the making of epidemiological numbers in global mental health, this study contributes to debates on the relationship between translation and culture.

Keywords: Cultural Translation; Psychiatric Epidemiology; Science Ethnography; CIDI 5.0.

The mental health care system for children and adolescents in Mozambique: A systematic review with framework synthesis

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Introduction: Mozambique is home to 25 million children and adolescents facing climate disasters, armed conflict, and structural poverty. This humanitarian crisis requires an appraisal of the mental health care system's capacity.

Method: We systematically reviewed population health status and healthcare system, including health indicators, qualitative evidence, and regulatory documents. We searched PubMed, Web of Science, CINAHL, PsycInfo, Google Scholar, African Index Medicus, and institutional catalogues (Government, WHO, UNICEF, World Bank) up to November 2025. Data analysis followed a best-fit framework synthesis using the WHO's health-system building blocks.

Results: We included 46 articles, 14 regulatory documents, and 34 institutional reports. Population data lack mental health indicators, but reveal concerns on social determinants, with 41.3% of people under 18 experiencing multidimensional poverty. Mozambique has a community-based, stepped-care system with a strong youth mental health framework. However, dedicated programmes are limited to HIV and epilepsy care, with fewer than 10% of symptomatic adolescents accessing formal care. The general health-worker density is fivefold below basic needs, and service delivery relies heavily on mid-level Psychiatric Technicians. There are only 5 medical schools nationwide, and psychiatry residency requires training abroad, with only 4 registered child psychiatrists in 2025. There is a chronic underfinancing, with health expenditure half necessary to deliver basic services and no dedicated mental health allocation. Mozambique never met the 15% health budget goal pledged under the 2001 Abuja commitment.

Conclusion: The development of child and adolescent mental health services remains in early stages, hampered by limited institutional capacity, lack of dedicated funding, and a critical shortage of specialized workforce. This pattern mirrors post-colonial sub-Saharan African contexts, where international agencies have historically driven mental health service development. There is a need to expand national postgraduate and specialist training to build local capacity of human resources. Pathways to strengthen public health financing involve improving funding and allocation mechanisms, as well as establishing dedicated mental health budgets. The WHO mhGAP-based epilepsy programme represented a landmark model for integrating mental health into primary care, offering a valuable model for training non-specialist providers, implementing clinical protocols, and establishing care pathways.

Funding: The Stavros Niarchos Foundation (SNF).

Understanding barriers and facilitators to disclosure of suicidal thoughts: A qualitative analysis of anonymous posts in Reddit

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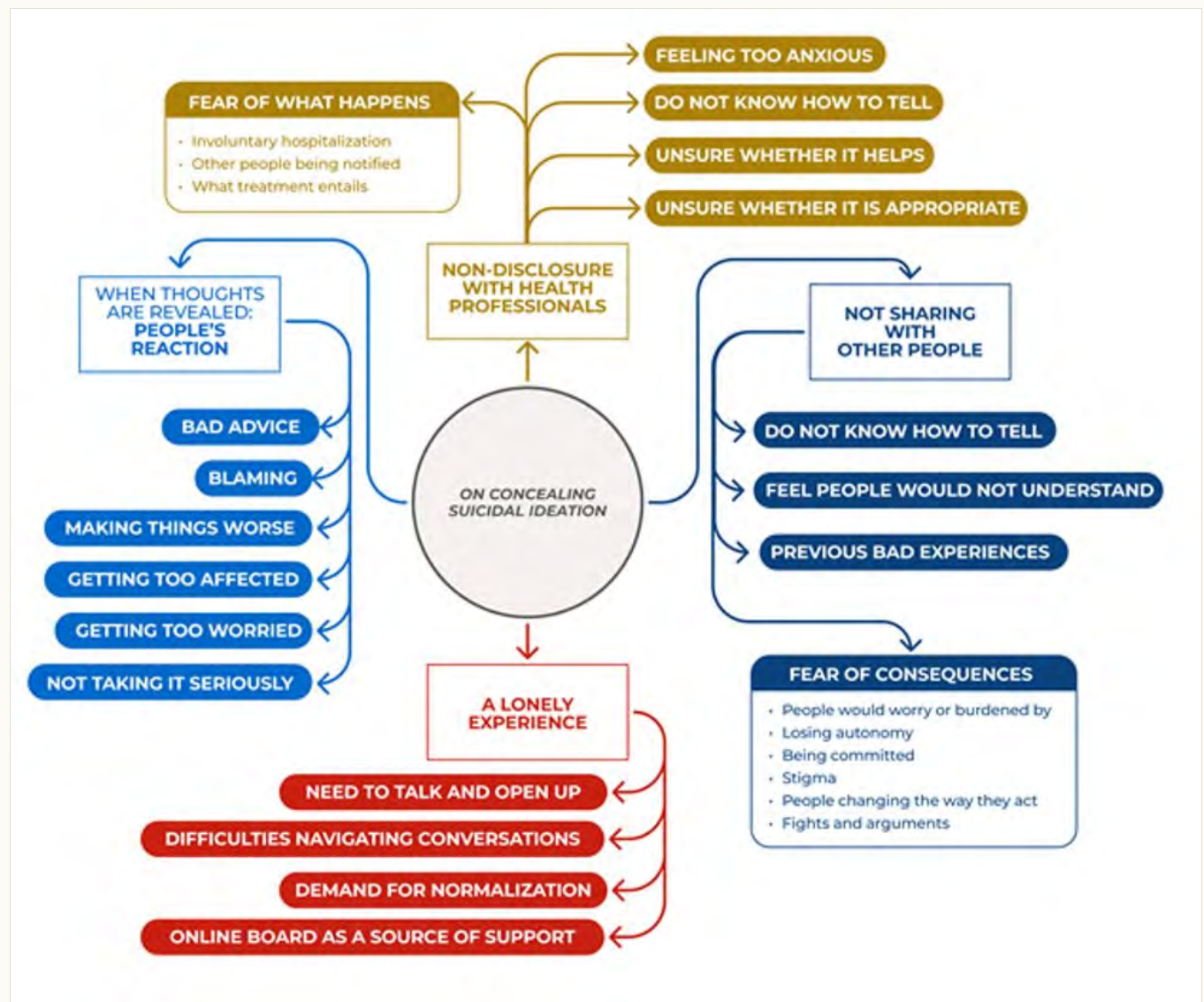
Introduction: Suicidal thoughts are distressing and often arise amid emotional suffering and life adversities. The isolation accompanying these thoughts exacerbates the burden, as many individuals do not disclose their experiences even within therapeutic settings. While suicide stigma poses a challenge for research, using anonymous, naturally occurring online narratives is opportune for exploring tabooed topics. This study explores the barriers and facilitators of disclosing suicidal thoughts through a qualitative analysis of spontaneous online reports.

Methods: We utilize secondary online data from the subreddit “r/depression” on Reddit, where users frequently discuss their experiences with suicidal thoughts using pseudonyms. A Python script was developed to collect 668 posts and their discussions containing relevant terms. Following manual cleaning and deduplication, 495 posts were selected for inductive thematic analysis.

Results: We found four main themes (see Figure 1): “reasons for non-disclosure with mental health professionals,” “reasons for not sharing with other people,” “people’s reactions,” and “a lonely experience”. Tables 1 and 2 provide illustrative quotes. Users expressed doubts about how health professionals handle suicidal thoughts, citing barriers such as fear of involuntary hospitalization and breaches of confidentiality, even for those without intent or planning. Regarding friends and family, primary deterrents included fear of causing worry, facing stigma, or being misunderstood and blamed. Participants emphasized the importance of destigmatizing the topic to discuss their feelings without being considered a risky person. Many users reported regret and avoidance of future disclosures due to judgmental responses, although some noted positive outcomes when met with empathetic attitudes. While people expressed a need to open up about their suicidal thoughts, they often felt unable to navigate these conversations. The online community provided a safe space and anonymity for individuals not sharing their thoughts elsewhere.

Conclusions: This study highlights the challenges individuals face in communicating their suicidal thoughts, underscoring the need to normalize this experience and foster supportive environments. The analysis sheds light on the low rates of identifying suicidal ideation in health settings, highlighting patient-perceived barriers. Beyond improving risk assessment, a therapeutic focus on helping individuals cope with their experiences is essential for effective support and understanding.

Themes on concealing suicidal ideation



IMG 1 · THEMATIC MAP

Concealing from health professionals

Table 1. Reasons for concealing suicidal thoughts from health professionals

Reason (number of posts)	Illustrative quotation
Fear of being committed (22)	<i>"With the frequency I have them, I'm scared he will put me in a mental hospital."</i>
Unsure of how professionals handle disclosure (10)	<i>"What happens when you tell a doctor about having suicidal thoughts? Do they freak out? Is it bad to tell them? I'm afraid of telling because I don't know what happens in general."</i>
Fear of confidentiality break (5)	<i>"As a police officer, If I tell my psychiatrist about my suicidal thoughts (which I don't want to act on), would she have to to inform my job? I won't tell if that's going to change what I can do at work."</i>
Feeling too anxious at the time (3)	<i>"I've shared a few times with some doctors and therapists. It scared me at first, maybe I felt it was like admitting defeat. I had this anxious idea that it'd be some horrible point of no return, that everyone would get to know it and would look at me differently"</i>
Do not know how to tell (2)	<i>"How to you tell your therapist you've been having suicidal ideation? I've already booked an appointment, but I don't know how I could simply get there and say "oh I've been thinking about killing myself".</i>
Unsure whether it is appropriate (2)	<i>"Can I talk about suicidal thoughts with my therapist?"</i> <i>"I have never told my therapist about it, and that's stupid, I know. I told my previous therapist, but that was never brought up again. That was confusing, I don't know if he forgot it, if it was not appropriate, if I was just too dramatic. So I never mentioned it up again. "</i>
Unsure whether it helps (1)	<i>"If I tell, is there <u>anyway</u> they can actually help with that?"</i>

Concealing from personal relationships

Table 2. Reasons for concealing suicidal thoughts from personal relationships

Reason (number of posts)	Illustrative quotation
Fear of worrying or burdening people (14)	<i>"I feel it is wrong to lay that burden on my spouse's shoulders."</i>
Fear of stigma (9)	<i>"I couldn't tell anyone. My friends would believe I'm crazy."</i>
Do not know how to tell (8)	<i>"Can't even know how to start. How do you tell the most important people in your life that you truly don't feel like living anymore?"</i>
Feel that people would not understand (6)	<i>"I certainly need people I could talk about this with, my friends would not understand it"</i>
Fear of fights and arguments (3)	<i>"I need a safe place to discuss it without being a burden or inciting the fights and arguments of dramatic saviour hood."</i>
Fear of hospitalization (3)	<i>"If I told my friends, I'd bet my chances they wouldn't do <u>nothing</u> or even <u>baker act me</u>."</i>
Fear of losing autonomy (1)	<i>"My parents would not allow me to do anything anymore and would destroy my independence. This would make me feel even worse."</i>

Trends in moderate-to-severe psychological distress amongst U.S. Hispanic adults: Evaluating differences by Hispanic origin and race, 2006–2015

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The Hispanic population in the US experiences social stressors such as discrimination and acculturative stress which can negatively impact their mental health. However, studies often analyze Hispanic as a homogenous population which can mask disparities between different Hispanic-origin groups. Moreover, racial identification within Hispanic groups have been mostly overlooked in studies which hides how Hispanics are exposed and positioned within the US racialized system. We examined trends in moderate-to-severe psychological distress among the US Hispanic population from 2006 to 2015 and evaluated whether differences by Hispanic origin varied by self-identified race.

We analyzed repeated data from 47,758 Hispanic adults from the 2006–2015 National Health Interview Survey (NHIS). Moderate-to-severe psychological distress was defined as a Kessler-6 score ≥ 5 . Hispanic origin was categorized as Mexican, Puerto Rican, Caribbean Hispanic (including Cubans and Dominicans), or Central/South American. Race was categorized as White, Black, or Multiracial/other. We estimated annual trends and Hispanic origin by year interactions using survey-weighted logistic regression models. Additionally, we assessed interaction by Hispanic origin and self-identified race to detect any effect modification. Models were adjusted by age, sex, education, poverty status, employment status, marital status, region of residence, and nativity. We also conducted design-adjusted Wald tests for interaction terms and estimates adjusted prevalence estimates.

Puerto Ricans had the highest crude prevalence of moderate-to-severe psychological distress (range 21.7% – 31.2%) compared to Mexicans (range 15.1% – 22.6%). Even after adjusting Puerto Ricans retained the higher prevalence (range 20.2% – 28.3%) compared to Mexicans (16.5% – 23.8%). Trends did not differ significantly by Hispanic origin ($p=0.121$). White, Black, and Multiracial/other Puerto Ricans had higher adjusted prevalences (23.7%, 24.7%, and 30.5%) than Mexicans (respectively, compared with 20.0%, 22.2%, and 25.0%). However, there was no evidence of effect modification by race ($p=0.417$).

This study shows that disaggregating Hispanic adults by origin and race could explain the heterogeneity in psychological distress. Puerto Ricans consistently had higher prevalence of psychological distress compared to Mexicans and across different race groups. These findings highlight the need to investigate the social, structural, and historical conditions underlying the elevated burden of psychological distress among Puerto Rican adults.

Users and professionals in two evolving mental health systems: A rights-based comparison between Italy and Albania

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Background: Quality of care, organizational well-being, and respect for human rights are key indicators of mental healthcare systems. The WHO QualityRights initiative, inspired by the United Nations Convention on the Rights of Persons with Disabilities (CRPD), provides a framework for monitoring these domains. Italy and Albania represent mental healthcare systems at different stages of development. Italy has a long-established community model but continues to face organizational and workforce challenges, whereas Albania is strengthening its mental health services through reforms aligned with European standards. This study compared service users' and healthcare professionals' perceptions in the two countries.

Methods: A cross-sectional study was conducted in 2025 within the multicenter project Perception of Human Rights and Quality of Care in Mental Health Services. Service users and healthcare professionals were recruited in Cagliari (Italy) and Tirana (Albania). Participants completed the appropriate WWRR version. Cross-country comparisons were performed separately for users and professionals using χ^2 tests and one-way ANOVA.

Results: Distinct patterns emerged. Italian service users reported higher satisfaction with services (5.48 ± 0.92 vs. 4.96 ± 0.99 ; $p = 0.005$), service organization (5.20 ± 1.23 vs. 4.63 ± 1.29 ; $p = 0.020$), and users' rights (5.47 ± 1.07 vs. 4.66 ± 1.24 ; $p < 0.001$). No significant difference emerged for staff rights. Albanian users reported greater perceived resource adequacy (1.39 ± 0.48 vs. 2.35 ± 0.95 ; $p < 0.001$). Albanian healthcare professionals reported higher perceived user satisfaction (4.85 ± 1.01 vs. 4.38 ± 0.96 ; $p = 0.011$) and organizational satisfaction (4.30 ± 1.28 vs. 3.43 ± 1.38 ; $p = 0.001$), whereas perceptions of users' and staff rights did not differ significantly. Workforce priorities also differed, with Albanian participants emphasizing physicians and nurses and Italian participants emphasizing broader multidisciplinary workforce needs.

Conclusions: Comparing service users' and healthcare professionals' perspectives provides a broader understanding of mental healthcare systems than either viewpoint alone. Although perceptions of organizational quality differed between countries, respect for human rights emerged as a consistent dimension, supporting cross-country evaluation. Integrating users' and professionals' experiences into service evaluation may guide mental health policy, support service reforms, and promote equitable, community-oriented, recovery-oriented systems of care.

WWRR dimensions: Italy and Albania

Table 1. Comparison of WWRR dimensions between service users and healthcare professionals in Italy and Albania

WWRR Domain	Users (Albania) m, SD	Users (Italy) m, SD	p	Professionals (Albania) m, SD	Professionals (Italy) m, SD	p
<i>Satisfaction with services/work</i>	4.96 ± 0.99	5.48 ± 0.92	0.005	4.65 ± 1.06	4.19 ± 1.32	0.052
<i>Organizational satisfaction</i>	4.63 ± 1.29	5.20 ± 1.23	0.020	4.30 ± 1.28	3.43 ± 1.38	0.001
<i>Respect for users' rights</i>	4.66 ± 1.24	5.47 ± 1.07	<0.001	4.60 ± 1.30	4.57 ± 1.35	0.905
<i>Respect for staff rights</i>	4.90 ± 1.12	5.10 ± 1.12	0.361	4.37 ± 1.17	4.07 ± 1.49	0.258
<i>Resource adequacy*</i>	1.39 ± 0.48	2.35 ± 0.95	<0.001	2.65 ± 0.85	3.00 ± 0.99	0.052

*Lower scores indicate greater perceived adequacy of resources (reverse-coded item).

Reframing mental health language to access and engage with people from indigenous, migrant and culturally diverse populations

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Background: This study aims to understand the use of mental health services among Bantu men in Adelaide, South Australia. Evidence shows there is a consistent pattern of lower rates of mental health service utilisation by immigrant and refugee populations, and it is not clear if they have benefited from the process of major state and federal mental health reforms. This situation of low rate of mental health service utilisation despite a higher prevalence of mental health issues in the Bantu people has existed for decades.

Aim: This research seeks to understand the factors influencing low utilisation of mental health services among Bantu men in Adelaide, South Australia. The research was guided by an overarching aim of understanding the low uptake of mental health services by Bantu men, when the prevalence of mental illness is relatively high in that migrant population.

Methods: The theoretical and methodological perspectives of the proposed qualitative research utilise a cultural lens and the 'Ubuntu' six cultural principles of Humility, spirituality, solidarity, reciprocity, harmony, and social justice to explore the influences on mental health services utilisation by Bantu people in Adelaide. Semi-structured interview questions were utilised. The researcher used a reflexive thematic analysis.

Results: Seven themes that emerged from the data were stigma and cultural beliefs, informal systems (way of healing), communication challenges, knowledge and awareness gap, confidentiality, migration and settlement challenges, patriarchal systems, and enablers.

- A salient theme emerging from the data is the concept of mental health language, which I define as the linguistic and conceptual framing of mental illness within Bantu cultural contexts.

Conclusion/Implications

- There is an urgent need to provide culturally sensitive mental health support services. The existing models of care, which are focused on Western-based individualised perspectives on psychological wellness and wellbeing, tend to alienate migrant men who have culturally bound conceptions of mental illness may pathologise culturally normative behaviours or reinforce stigmatisation in unexpected ways. Cultural interventions must consider social history of the person being supported, particularly regarding how gender norms and migration affect help-seeking behaviour.



Poster Session II

Thursday, October 1st, 2026

(PP 31 - PP 60)

Adaptive hyperactivity and cognitive trade-offs in older adults: Evidence from pooled data

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Introduction: Elevated levels of energy and behavioral activation in older adults have been associated with favorable psychological outcomes, including lower depressive symptoms, better regulation of social rhythms, and higher perceived quality of life. However, emerging evidence suggests that this apparently adaptive profile may coexist with lower performance in selected cognitive domains. This study aimed to assess whether high self-reported hyperactivity in older adults is associated with favorable psychological functioning and distinct patterns of performance across selected cognitive domains.

Method: We analyzed pooled data from two independent cohorts of community-dwelling older adults aged ≥65 years. Participants were classified according to self-reported hyperactivity using item 10 of the 12-item Short Form Health Survey (SF-12), previously validated as a brief screening tool for identifying elevated energy and behavioral activation. The pooled analysis compared participants with high self-reported hyperactivity (score = 6; N = 26) with those reporting low hyperactivity (scores = 1–4; N = 125). Cognitive performance was assessed using the Addenbrooke's Cognitive Examination-Revised (ACE-R). Depressive symptoms, quality of life, and social rhythm regulation were assessed using the Patient Health Questionnaire-9 (PHQ-9), the SF-12 total score, and the Brief Social Rhythms Scale (BSRS), respectively.

Results: In the pooled dataset, high- and low-hyperactivity groups did not differ significantly in sex, age, or educational level. High-hyperactivity participants showed lower depressive symptoms, better rhythm regulation, and higher perceived quality of life. They showed lower cognitive performance in the total ACE-R score (85.52 ± 9.30 vs. 89.12 ± 6.20 ; $P = 0.015$), with significant differences also observed in attention and orientation, memory, verbal fluency, and language. Visuospatial skills showed the same direction of association, without reaching statistical significance.

Conclusion: Pooled data suggest that high self-reported hyperactivity in older adults may identify a subgroup characterized by favorable psychological functioning but lower performance in selected cognitive domains. Rather than indicating generalized decline, this pattern may reflect a functional cognitive trade-off or a distinct processing profile. Longitudinal studies using process-oriented cognitive measures are needed to clarify the mechanisms underlying this profile.

Keywords: Adaptive Hyperactivity; Cognitive Performance; Psychological Functioning; Social Rhythms

Funding: The study is funded by Fondazione di Sardegna

High vs. low hyperactivity groups

Table 1 - Comparison of sociodemographic characteristics, depressive symptoms, social rhythm dysregulation, and quality of life between high and low hyperactivity groups

	Sex (female) N (%)	Age, years Mean $\pm$ SD	University degree or higher N (%)	PHQ-9 Total Score Mean $\pm$ SD	BSRS Total Score Mean $\pm$ SD	SF-12 Total Score Mean $\pm$ SD
High hyperactivity (N=26)	16 (61.5%)	73.11 $\pm$ 3.90	6 (27.08%)	1.15 $\pm$ 1.40	16.26 $\pm$ 5.99	39.53 $\pm$ 3.80
Low hyperactivity (N=125)	76 (60.8%)	73.49 $\pm$ 4.84	43 (34.4%)	4.03 $\pm$ 3.42	21.39 $\pm$ 7.58	32.33 $\pm$ 4.50
High vs. low	$\chi^2(1) =$ 0.005; P = 0.944	F(1,149) = 0.146; P = 0.703	$\chi^2(1) =$ 1.259; P = 0.262	F(1,149) = 17.741; P < 0.001	F(1,149) = 10.399; P = 0.002	F(1,149) = 57.886; P < 0.001

Legend. Values are reported as n (%) or mean $\pm$ standard deviation. Hyperactivity groups were defined according to SF-12 item 10: high = score 6, low = scores 1–4. PHQ-9 = Patient Health Questionnaire-9; BSRS = Brief Social Rhythms Scale; SF-12 = 12-item Short Form Health Survey. Higher BSRS scores indicate greater rhythm dysregulation. Group comparisons were performed using one-way ANOVA or chi-square tests.

Table 2 - Comparison of cognitive performance between high and low hyperactivity groups

	High hyperactivity (SF-12 item 10 = 6) N = 26 (N=15+11)	Low hyperactivity (SF-12 item 10 = 1–4) N = 125 (N=67+58)	High vs. low F (1, 149), P
ACE-R total score	85.52 $\pm$ 9.30	89.12 $\pm$ 6.20	F=5.998 P=0.015
Attention and Orientation	17.30 $\pm$ 1.28	17.75 $\pm$ 0.85	F=4.974 P=0.027
Memory	21.07 $\pm$ 4.72	23.09 $\pm$ 3.54	F=6.199 P=0.014
Verbal Fluency	8.77 $\pm$ 2.52	10.71 $\pm$ 2.53	F=12.672 P<0.001
Language	24.11 $\pm$ 3.11	25.00 $\pm$ 1.52	F=4.808 P=0.030
Visuospatial skills	14.07 $\pm$ 2.03	14.70 $\pm$ 1.57	F=3.122 P=0.079

Values are reported as mean $\pm$ standard deviation. ACE-R = Addenbrooke's Cognitive Examination-Revised. Hyperactivity groups were defined according to SF-12 item 10: high = score 6, low = scores 1–4. Group comparisons were performed using one-way ANOVA.

Adverse childhood events predicting cognitive complaint but not neuropsychological scores in older adults: Results from a large population-based study

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Introduction: The role of different Adverse childhood events (ACEs) on cognitive complaint and neuropsychological course in older people remains under debate. Accordingly, we aimed to prospectively assess the associations between ACEs with cognitive complaint and the evolution of neuropsychological scores in a large population-based cohort, and to evaluate the possible mediating/moderating role of inflammation.

Methods: Data stemmed from CoLausPsyCoLaus, a prospective population-based cohort of initially 6734 participants followed-up for 20 years. The present sample included 1012 participants over 65. Diagnostic criteria for ACEs were elicited using semi-structured interviews; cognitive complaint was assessed with an auto-questionnaire. A neuropsychological battery assessed memory, language, attention and executive functions. The relationship between the different ACEs and the 5-year risk of having cognitive complaint was assessed with multiple logistic regression. Mixed Linear models measured the association between ACEs and the 10-year evolution of neuropsychological scores. The role of inflammation will be assessed with mediation models. The analyses were adjusted for age, sex, education, depression, anxiety disorders, and psychotropic drugs.

Results: Participants with a history of childhood abuse or parental physical fighting exhibited increased cognitive complaint in comparison to those without (respectively OR 4.35; p=0.002 and OR 1.73, p=0.03). On the other hand, our results did not show any relationship between ACEs and neuropsychological scores. Inflammation variables were associated with ACEs but not with cognition.

Conclusion: Our results suggest that early trauma is associated with low self-esteem in cognitive skills, while normal neuropsychological performance. These findings highlight the importance of considering childhood adversity when examining cognitive complaint.

Chronic pain intensity predicts long-term depressive disorders in older community-dwellers

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Introduction: Chronic pain (CP) was associated with depression in older people in numerous cross-sectional studies. However, the longitudinal association between CP characteristics and depressive symptoms in this population remains under debate. We aimed to assess the prospective link between CP intensity and long-term depressive symptoms in a population-based cohort of older participants, considering covariables linked to CP and depressive symptoms.

Methods: The study sample was selected from the PAQUID study, an ongoing cohort of older community-dwellers aged 65 years and over at baseline. Seven hundred and thirteen participants filling out a CP questionnaire were included. Information regarding CP characteristics was collected using a questionnaire administered at the 3-year follow-up. Depressive symptoms were assessed every 2 to 3 years during 12 years with the CES-D scale. The association between CP and the 12-year evolution of CES-D score was investigated using a multivariate latent process mixed model for curvilinear data.

Results: Compared with participants without CP, those with mild and intense CP had significantly higher CES-D levels at baseline with a dose-response relationship as a function of pain intensity ($\beta = 0.391$, $p = 0.0224$, and 0.696 , $p < .0001$, respectively). However, the time course was comparable in the three groups ($\beta = -0.003$, $p = 0.8406$, and 0.001 , $p = 0.9617$, for mild and intense CP respectively). CP intensity was associated with higher levels of depressive symptoms persisting over long follow-ups.

Conclusions: This finding reinforces the importance of active treatment of CP in older subjects, to prevent its consequences, including depressive symptoms.

Early-life adversity predicting the incidence of functional pain in the general population

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Introduction: Adverse childhood events (ACEs) have been linked to widespread chronic pain (CP) in various cross-sectional studies, mainly in clinical populations. However, the independent role of different ACEs on the development of different types of CP remains elusive. Accordingly, we aimed to prospectively assess the associations between specific types of ACEs with the development of multisite CP in a large population-based cohort.

Methods: Data stemmed from the three first follow-up evaluations of CoLausPsyCoLaus, a prospective population-based cohort study of initially 6734 participants (age range: 35-75 years). The present sample included 1537 participants with 2161 analysable intervals (49.7% men, mean age 57.3 years). Diagnostic criteria for ACEs were elicited using semi-structured interviews, CP was assessed by self-rating questionnaires. Multinomial logistic regressions with Generalized Estimating Equations method analysed the relationship between the different ACEs measured in the beginning of the interval and the risk of developing multisite CP during the follow-up. Sensitivity analyses were performed to assess the predictive value of ACEs on multisite CP with neuropathic features.

Results: Participants with a history of parental divorce or separation had an increased risk of developing multisite CP at during follow-up in comparison to those without (RR 1.98; 95% CI 1.13-3.47). A strong association was highlighted between parental divorce or separation and the risk of subsequent CP with neuropathic characteristics (RR 4.21, 95% CI 1.45-12.18).

Conclusions: These results highlight the importance of psychotherapeutic management of people experiencing parental separation to prevent CP, in the future.

Age, period, and cohort trends in suicidal behaviors in France: Findings from eight national surveys from 2000 to 2023

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Introduction: Suicidal ideation and attempted suicide are the most proximal predictors of completed suicide and are associated with a significant societal burden. We aimed to assess age, period, and cohort trends in past-year suicidal ideation and lifetime suicide attempts over the past two decades among females and males to identify at-risk groups.

Method: The current study draws on data from the last eight Health Barometer French national representative sample surveys conducted between 2000 and 2023 on 141,820 respondents. Age-period-cohort (APC) analysis was used to model the presence of past-year suicidal ideation. We modeled age, period, and cohort as continuous variables using restricted cubic spline functions in males and females. The identification problem was addressed by imposing constraints on the period and cohort effects. Predictors of suicidal behaviors were also assessed in GLM models (Poisson family with a log link, adjusted for socio-demographic covariates including sex, education, income, region, and professional status).

Results: The fully adjusted generalized linear models showed statistically significant independent effects for age, period, and cohort on past-year suicidal ideation (all p-values < 0.001). In females, the predicted risk of past-year suicidal ideation was highest in younger age, decreasing in middle adulthood, with an increase in risk between ages 45 and 55, and a subsequent decrease in older age groups. The predicted risk in males peaked between 25 and 30 years of age and then declined with age. Regarding cohort effects, an inverted S shape is observed in both males and females. Relative to the 1965 reference cohort, among males, the highest risk is seen in those born in 1945, and the lowest in those born in 1990; among females, the highest is seen between 1935 and 1940 and the lowest in those born in 1990. A more pronounced increase was observed in males born thereafter. Period effects show a more pronounced increase in males after 2020.

Conclusions: The findings from this study, collected from eight cross-sectional national surveys, show the importance of including age, period, and cohort effects in identifying high-risk groups for prevention strategies for suicidal behaviors.

Food insecurity, received support and mental health outcomes among adults experiencing socioeconomic disadvantage in Québec, Canada

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Introduction: Food insecurity is a social determinant of mental health and is highly prevalent among socioeconomically disadvantaged populations. Although support is often considered protective, its association with mental health in the context of food insecurity remains unclear. This study examined the association between the joint effect of food insecurity and received support and mental health outcomes among adults living in poverty in Québec (Canada).

Methods: This cross-sectional study included 500 adults living in poverty in Québec, Canada, recruited through the Léger Opinion online panel in 2025. Mental health outcomes included were anxiety (GAD-7 ≥ 8), depression (PHQ-8 ≥ 10), and suicidal ideation (SI; PHQ-9), dichotomized (no SI versus any SI). A four-category variable combined food insecurity and support (informational, material, or financial support from family, friends, community organizations, or public authorities): (1) no food insecurity/no support, (2) no food insecurity/support, (3) food insecurity/no support, and (4) food insecurity/support. Logistic regression models were adjusted for physical activity, sex, age, education, and employment status.

Results: Compared with participants reporting neither food insecurity nor support receipt, several groups showed significantly greater odds of adverse mental health outcomes. For anxiety, participants reporting no support and food insecurity had twice the odds of anxiety, while those reporting support and food insecurity had four times the odds of anxiety compared with the reference group. For depression, participants with support but no food insecurity had 4.5 times the odds, those with food insecurity but no support had 2.6 times the odds, and those with both food insecurity and support had 6.4 times the odds. For SI, participants with food insecurity but no support had 3.5 times the odds, while those with both food insecurity and support had 4.8 times the odds. Overall, food insecurity was consistently associated with poorer mental health outcomes, regardless of received support.

Conclusions: Food insecurity was consistently associated with poorer mental health outcomes among adults living in poverty. Participants experiencing food insecurity had greater odds of anxiety, depression, and SI regardless of support receipt. Longitudinal studies are needed to clarify the joint effects of food insecurity and support on mental health in socioeconomically disadvantaged populations.

Child-birth related trauma and PTSD in Nigeria: Prevalence and associated factors

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Introduction: Pregnancy and childbirth are associated with significant physiological, psychological and social change for women. Although childbirth is viewed as a positive experience, many women find childbirth psychologically traumatic and many go on to develop post-traumatic stress disorder (PTSD) related to the birth experience. Little is known about these pregnancy- and birth-related conditions in many low- and middle-income countries.

Methods: The international survey of childbirth-related trauma (INTERSECT) was conducted in 31 countries from different parts of the world. This report focuses on the data from Nigeria. In a cross-sectional study, 406 consecutive women attending routine infant immunization clinics, who were 16 years or older and within 5-12 weeks postpartum were recruited from 4 primary healthcare centers (2 rural and 2 urban) in Ibadan Nigeria. They were interviewed with the Yoruba version of the Edinburgh Postnatal Depression Scale (EPDS), the City Birth Trauma Scale (City BITS), a 29-item scale for childbirth-related trauma and DSM-5 diagnosed PTSD.

Results: The mean age of participants was 28.7 [SD=5.68] years. Majority of them were married or living with a partner (95.5%), had vaginal delivery (89.5%) and were multiparous (62.6%). Childbirth related trauma was reported in 13.6% and PTSD in 1.23%. In multivariable logistic regression analyses, previous history of any trauma (AOR [95%CI]- 3.01 [1.57-5.75]), caesarean section (elective CS 3.62 [1.35-9.71]; emergency CS 7.25 [2.18-24.09]), and major maternal complications (8.75 [1.66-46.27]) were independently associated with increased odds of traumatic birth experience. Conversely, women with high income had reduced odds of birth trauma (0.43 [0.19-0.97]), compared to those in the low-income category. Higher PTSD severity scores were associated with birth trauma in index birth (β coefficient, p value: 2.14, <0.001), higher EPDS score (0.45, <0.001) and elective CS (1.91, 0.001).

Conclusion: The findings from this study draw attention to the relatively high rates of traumatic birth experience and highlight a need for maternal and child healthcare services to devise and implement measures that protect women from childbirth related stressors.

Cumulative clinical workload burden and depression among hospital-affiliated resident trainees in China: A multicenter, propensity score-weighted, prospective cohort study

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Introduction: Clinical workload may contribute to depression among hospital-affiliated resident trainees, yet longitudinal evidence remains limited in non-Western settings. This study examined whether clinical hours, electronic health records (EHR) use, and night shifts were associated with depression, and whether working-hour autonomy modifies these associations.

Methods: We analyzed data from a propensity score-weighted, prospective cohort of 2,890 hospital-affiliated resident trainees from 25 hospitals in China, with two waves of data collected in September 2025 and April 2026. Depression was defined as having a PHQ-8 total score ≥ 7 at follow-up among participants without baseline depression. High-burden indicators were clinical hours ≥ 60 /week, EHR use ≥ 2 hours/day, and night shifts ≥ 2 days/week, respectively. Cumulative workload burden was operationalized as the number of high-burden indicators, ranging from 0 to 3. Modified Poisson regression was used to estimate risk ratios (RR) for depression, adjusting for demographics, training details, and behavioral factors. Interaction terms tested effect modification by working-hour autonomy.

Results: Among 2,890 participants without baseline depression, 285 reported depression at follow-up (9.86%), ranging from 8.45% with no high-burden indicators to 10.41%, 14.16%, and 17.71% with one, two, and three high-burden indicators, respectively. When examined individually in separate adjusted models, high clinical hours (RR, 1.56; 95% CI, 1.16–2.10; $p = .004$), high EHR use (RR, 1.32; 95% CI, 1.02–1.70; $p = .035$), and frequent night shifts (RR, 1.58; 95% CI, 1.19–2.09; $p = .001$) were each associated with a higher risk of depression. In an adjusted model with the cumulative workload burden, each additional high-burden indicator was associated with increased risk (RR, 1.29; 95% CI, 1.13–1.47; $p < .001$). Working-hour autonomy modified associations for high clinical hours (interaction RR, 1.48; 95% CI, 1.17–1.87; $p = .001$), EHR use (interaction RR, 1.38; 95% CI, 1.11–1.72; $p = .004$), and cumulative burden (interaction RR, 1.17; 95% CI, 1.06–1.28; $p = .002$), but not frequent night shifts (interaction RR, 1.18; 95% CI, 0.93–1.49; $p = .165$).

Conclusion: Cumulative burden of clinical hours, EHR use, and night shift was associated with a higher risk of depression. Reducing cumulative clinical workload and improving working-hour autonomy may help protect trainee mental health.

Participant characteristics and incident depression

Table 1. Participant Characteristics and Incident Depression

Characteristic	Level	Overall	Non-case	Case	Incidence, %	P value
Clinical workload burden indicators						
Average weekly clinical working hours	<60 hours	2585 (89.45)	2346 (90.06)	239 (83.88)	9.25	.001
	≥60 hours	305 (10.55)	259 (9.94)	46 (16.14)	15.08	
Average daily length of EHR input	non or less than 2 hours	1999 (69.17)	1820 (69.87)	179 (62.81)	8.95	.014
	2 hours (included) or more	891 (30.83)	785 (30.13)	106 (37.19)	11.90	
Average weekly night shift	non or 1 day	2471 (85.50)	2248 (86.30)	223 (78.25)	9.02	<.001
	2 days (included) or more	419 (14.50)	357 (13.70)	62 (21.75)	14.80	
Burden count	0	1799 (62.25)	1647 (63.22)	152 (53.33)	8.45	<.001
	1	663 (22.94)	594 (22.80)	69 (24.21)	10.41	
	2	332 (11.49)	285 (10.94)	47 (16.49)	14.16	
	3	96 (3.32)	79 (3.03)	17 (5.96)	17.71	
Moderator						
Influence on working hours, score	Mean (SD)	11.45 (2.47)	11.57 (2.44)	10.38 (2.50)	—	<.001
Demographic and training characteristics						
Gender	Male	1062 (36.75)	947 (36.35)	115 (40.35)	10.83	.184
	Female	1828 (63.25)	1658 (63.65)	170 (59.65)	9.30	
Age, y	Mean (SD)	25.69 (2.26)	25.72 (2.25)	25.49 (2.35)	—	.032
Level of current education	Master	1658 (57.37)	1483 (56.93)	175 (61.40)	10.55	.147
	PhD or MD	1252 (42.63)	1122 (43.07)	110 (38.60)	8.93	
Enrollment year	2020	1 (0.03)	0 (0.00)	1 (0.35)	100.00	.010
	2021	3 (0.10)	3 (0.12)	0 (0.00)	0.00	
	2022	15 (0.52)	13 (0.50)	2 (0.70)	13.33	
	2023	800 (27.48)	732 (28.10)	68 (23.86)	8.50	
	2024	895 (30.97)	821 (31.52)	74 (25.96)	8.27	
	2025	1176 (40.69)	1036 (39.77)	140 (49.12)	11.90	
Research hours, h	Mean (SD)	81.11 (19.43)	81.17 (19.19)	90.75 (21.56)	—	.289
Health behavior and socioeconomic covariates						
Smoking status in the past 2 weeks	non-smoking	2823 (97.68)	2552 (97.97)	271 (95.09)	9.60	<.001
	less than 1 cigarette per week	20 (0.69)	16 (0.61)	4 (1.40)	20.00	
	1 to 3 cigarette per week	12 (0.42)	8 (0.31)	4 (1.40)	33.33	
	more than 3 cigarette per week	31 (1.07)	28 (1.07)	3 (1.05)	9.68	
	Use of E-Cigarette	4 (0.14)	1 (0.04)	3 (1.05)	75.00	
Drinking status in the past 2 weeks	non-drinking	2502 (86.37)	2281 (87.56)	221 (77.54)	8.83	<.001
	less than 8 grams per week	275 (9.52)	233 (8.94)	42 (14.74)	15.27	
	8 to 24 grams per week	75 (2.60)	64 (2.46)	11 (3.86)	14.67	
	more than 24 grams per week	38 (1.31)	27 (1.04)	11 (3.86)	28.95	
Monthly wage	Mean (SD), in CNY	3047.87 (1087.22)	3049.47 (1085.15)	3033.19 (1107.80)	—	.780
Regular exercise habit	no	1203 (41.63)	1050 (40.33)	153 (53.68)	12.72	<.001
	yes	1687 (58.37)	1555 (59.69)	132 (46.32)	7.82	

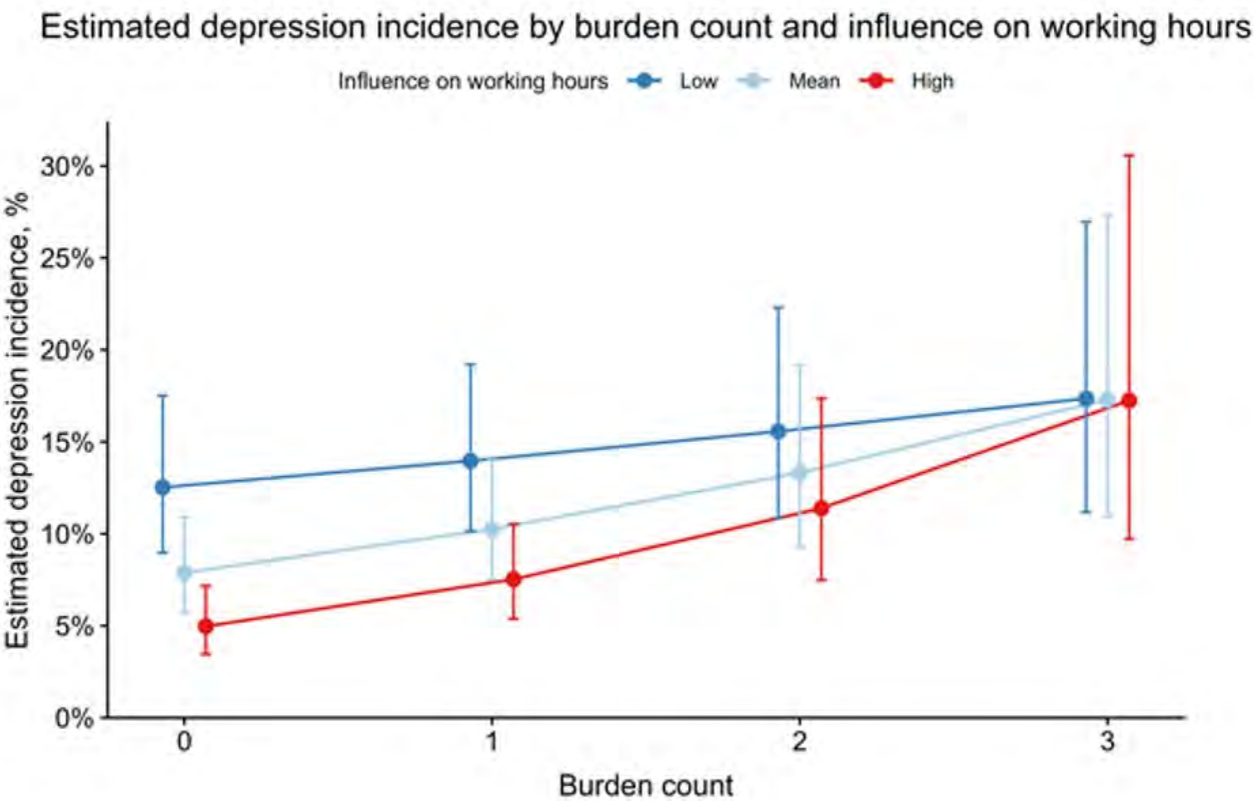
Weeks are for 262 unless otherwise indicated. Incidence values are percentages. EHR, electronic health record.

Workload burden and incident depression

Table 2. Associations of Clinical Workload Burden With Incident Depression

Clinical workload burden indicator	Definition	Control, cases/No. (%)	High burden, cases/No. (%)	Crude RR (95% CI)	P value	Adjusted RR (95% CI)	P value	Overlap-weighted RR (95% CI)	P value
High clinical hours	≥60 weekly	239/2585 (9.25)	46/305 (15.08)	1.63 (1.22-2.19)	.001	1.58 (1.16-2.18)	.004	1.50 (1.10-2.03)	.010
High EHR burden	≥2 hours daily	179/1999 (8.95)	106/891 (11.90)	1.33 (1.06-1.67)	.014	1.32 (1.02-1.70)	.035	1.26 (0.98-1.64)	.076
High night shift	≥2 days weekly	223/2471 (9.02)	62/419 (14.80)	1.64 (1.26-2.13)	<.001	1.58 (1.19-2.09)	.001	1.52 (1.15-2.02)	.004

RR indicates risk ratio; CI, confidence interval; EHR, electronic health record. Adjusted models included demographics, lifestyle, health behavior, and socioeconomic covariates; overlap-weighted estimates used the mean propensity score ratio.



ESTIMATED INCIDENCE BY BURDEN COUNT

Digital epidemiology of community mental health after collective trauma: An analysis of online communication following the tragedy at Vladislav Ribnikar primary school

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Introduction: The tragedy at Vladislav Ribnikar Primary School in Belgrade, on May 3, 2023, represents a collective trauma with potential impacts on psychological well-being, perceived safety, and community resilience. Digital platforms can provide insight into public responses that may remain underrecognized by traditional mental health surveillance systems. This study aims to analyze digital communication following the Ribnikar tragedy to identify patterns of collective distress, social support, health literacy, and perceived needs for public health responses.

Methods: A descriptive case series study based on digital content analysis was conducted to examine mental health-related communication following the Ribnikar tragedy. The study included only publicly available posts, without collection of personal or identifiable user data, in accordance with ethical principles for digital research. A total of 500 posts published between May 3 and November 3, 2023, were selected using purposive sampling based on visibility and engagement: Reddit (n=300), Krstarica forum (n=100), and X (n=100). Posts were selected according to predefined criteria, including thematic relevance, time frame, and interaction level. Posts were analyzed using deductive thematic analysis, with categories covering collective distress, risk perception, social support, health literacy, stigma, and perceived public health needs. Statistical analysis was performed in IBM SPSS Statistics using descriptive statistics, chi-square test, Fisher's exact test, Cramer's V, and Spearman's correlation.

Results: Collective distress was the most common theme (314; 62.8%), followed by risk perception/insecurity (276; 55.2%) and social support (238; 47.6%). Health literacy-related content was identified in 142 (28.4%) posts, stigma in 96 (19.2%), and perceived institutional or public health needs in 187 (37.4%). Theme distribution differed significantly across platforms ($\chi^2=18.64$; $p=0.005$), with Reddit showing more social support content (52.0%) and X more discussion of institutional responses (49.0%). Platform differences showed a moderate association with thematic patterns (Cramer's $V=0.19$). Higher post engagement was associated with more frequent collective distress content (Spearman's $\rho=0.21$; $p<0.001$).

Conclusion: Digital platforms may provide complementary insights into collective distress, social support, and mental health needs after traumatic events. Findings following the Vladislav Ribnikar Primary School tragedy highlight the potential of digital epidemiology to strengthen mental health surveillance and inform community-based public health responses.

Digital mental health promotion in university students: Effectiveness and implementability of the WHO doing what matters in times of stress intervention

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Introduction: University students frequently experience mental health challenges related to academic pressure, life transitions, and developmental factors. Scalable digital interventions may represent an effective strategy to support prevention and early intervention. This study aimed to evaluate the effectiveness and implementability of Doing What Matters in Times of Stress (DWM), a psychosocial e-mental health intervention developed by the World Health Organization, in reducing psychological distress and symptoms of anxiety and depression and improving well-being among university students.

Methods: We conducted a pre-post intervention study (October 2023–June 2024). Students were recruited through university communication channels and participated via web-based platforms. Self-reported measures were collected at baseline (T1) and post-intervention (T2), including psychological distress (K-10), depressive symptoms (PHQ-9), anxiety (GAD-7), and well-being (WHO-5). Implementability outcomes were assessed at T2. Wilcoxon matched-pairs signed-rank tests and logistic regression models were performed.

Results: A total of 1,498 (65.2%) completed all sessions and assessments. At baseline, participants showed mild levels of distress, anxiety, and depressive symptoms, with moderate well-being. Significant improvements were observed at T2: K-10 scores decreased from 22.41 to 19.86, GAD-7 from 8.27 to 6.57, and PHQ-9 from 8.28 to 6.75 (all $p < 0.001$). WHO-5 well-being scores increased from 11.73 to 13.26 ($p < 0.001$). Acceptability was high, with over 90% reporting satisfaction and 95% indicating the program was easy to use.

Conclusion: The DWM intervention demonstrated positive effects on student mental health, reducing distress, anxiety, and depressive symptoms while improving well-being. High acceptability and usability support the feasibility of scalable digital interventions for mental health promotion in university populations.

Epidemiological study of the incidence and distribution of dependence among community-dwelling older adults in Beijing

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Introduction: Dependence, defined as the need for assistance with basic or instrumental activities of daily living, is a common and serious functional problem in older adults, which is closely associated with poor quality of life and substantial caregiver burden. This study aimed to describe the 5-year cumulative incidence of dependence and its distribution by demographic and socioeconomic factors among older adults in urban and rural Beijing.

Methods: This study was part of the 10/66 Dementia Research Group project. Data were obtained from a baseline survey (2004–2006) and a follow-up survey (2008–2010) of 1,925 independently living individuals aged ≥ 65 years, recruited from 28 communities in Xicheng (urban) and Daxing (rural) districts. Dependence was defined using the standardized criteria developed by the 10/66 group. The 5-year cumulative incidence was calculated, and differences by region, sex, age, education, marital status, and monthly income were examined using chi-square tests.

Results: The overall 5-year cumulative incidence of dependence was 11.69% (95% CI: 10.25–13.12). The incidence was significantly higher in urban than in rural areas (15.46% vs. 7.81%, $P < 0.0001$), and higher in females than in males (13.15% vs. 9.82%, $P = 0.0242$). A clear increasing trend with age was observed, from 6.99% in those aged 65–69 years to 23.17% in those aged ≥ 85 years ($P < 0.0001$). Marital status was also significantly associated ($P = 0.0195$), with the highest incidence among widowed/divorced/separated participants (14.63%) compared with married/remarried (10.23%) and unmarried (13.04%). Monthly income showed significant differences ($P = 0.0024$), with the middle-income group (500–2000 RMB) having the highest incidence (14.49%), while the low (<500) and high (>2000) groups had lower rates (9.49% and 10.00%, respectively). No significant difference was found by education level ($P = 0.2604$).

Conclusions: The 5-year cumulative incidence of dependence in this Beijing cohort was substantial, with notable disparities by region, sex, age, marital status, and income. These findings highlight the need for targeted prevention and long-term care strategies, particularly for urban residents, females, and those with lower social support. Community-based interventions should focus on these high-risk subgroups to help delay or reduce the onset of dependence.

Distribution of 5-year cumulative incidence

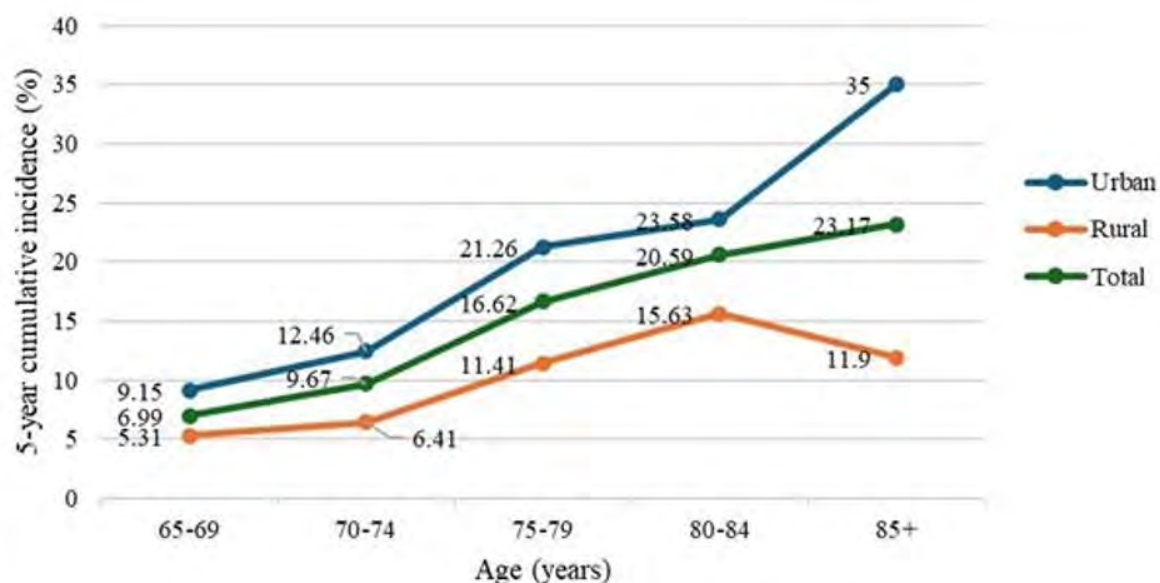


Figure 1. Urban-rural and age distribution of the 5-year cumulative incidence of dependence among older adults

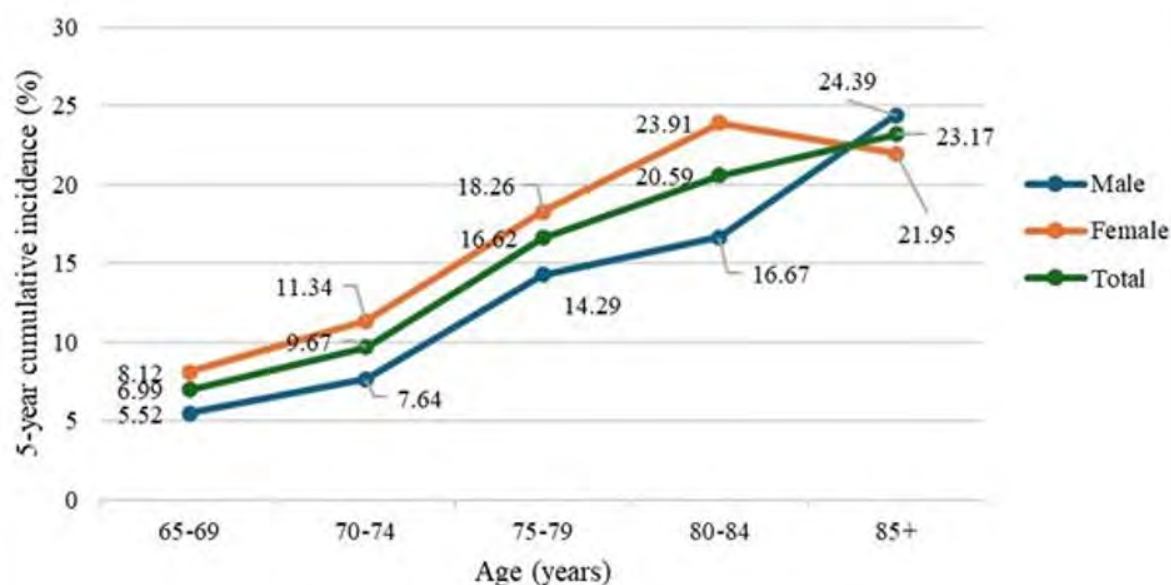


Figure 2. Gender and age distribution of the 5-year cumulative incidence of dependence among older adults

From digital triage to psychological distress: Problematic cyberchondria and healthcare avoidance among urban youth in India

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Background: The rapid use of artificial intelligence and social media has transformed how young adults seek health information. However, evidence of its influence on healthcare decisions among Indian youth remains limited. We investigated the prevalence of cyberchondria and digital health information-seeking behavior among college students in India, exploring how reliance on digital platforms influences healthcare-seeking decisions and healthcare provider trust.

Methods: A mixed-method cross-sectional study was conducted among youth (18–24 years; N=706) across nine randomly selected arts and science colleges (three government, aided and private each) in Chennai, Tamil Nadu. Quantitative data evaluating digital health habits and psychiatric morbidity via e-Health Literacy Scale (eHEALS-10) and Cyberchondria Severity Scale (CSS-12) were analysed. Qualitative insights were derived from thematic analysis of nine structured in-depth interviews.

Results: The mean eHEALS score was 22.47 ± 8.33 , with 64.9% participants demonstrating low eHealth literacy. Regarding psychiatric morbidity, 11.2% reported problematic cyberchondria (moderate to severe). Students with high eHealth literacy had a higher prevalence of problematic cyberchondria (18.1%) than those with low eHealth literacy (7.4%). Low eHealth literacy was significantly associated with younger age, undergraduate status, rural/semi-urban residence and enrolment in self-financing institutions compared to their counterparts. Government college students reported the lowest prevalence of problematic cyberchondria (6.2%), followed by self-financing (12.5%) and aided colleges (14.9%). Qualitatively, the “Reassurance Paradox” highlighted how searching for minor symptoms frequently exaggerates anxiety, such as misinterpreting minor pain or injuries as severe, life-threatening diseases. The “AI vs. Physician Trust Matrix” revealed students utilize AI for accessible triage but ultimately trust human doctors for physical check-ups and accountability. However, despite this trust, youths routinely delay definitive care and deliberately hide online self-treatments from providers, fearing judgement.

Conclusion: Digital triage is a dual-edged determinant of youth mental health. While offering accessible information, it paradoxically drives cyberchondria, algorithm-induced distress and critical delays in professional care, especially among highly digitally literate populations. Findings highlight the need for digital health literacy strategies that promote critical evaluation of online information and support healthy healthcare-seeking behaviors among young adults.

Acknowledgement: MAMTA Research Scholarship Excellence Award [ID: 2025-26/MD/003] in Adolescent Health (2026–27) by MAMTA Health Institute for Mother and Child.

Cyberchondria severity and eHealth literacy

Figure 1: Severity Levels of Cyberchondria Subscales (CSS-12) in Urban Youth (N=706)

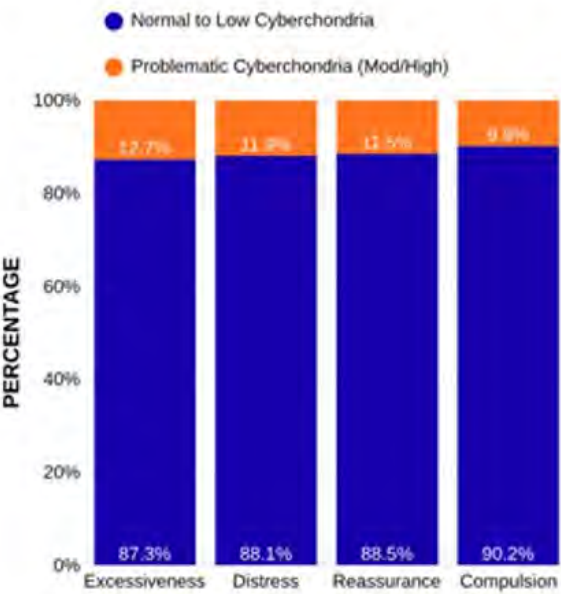
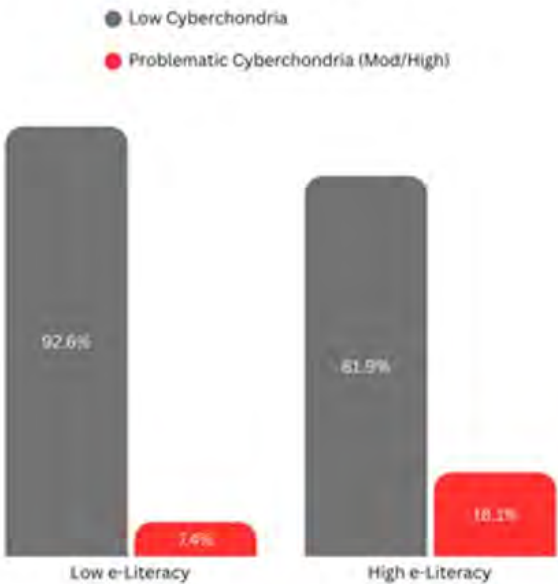


Figure 2: Prevalence of Problematic Cyberchondria Stratified by eHealth Literacy Levels (N=706)



Sociodemographic factors

Table 1: Sociodemographic Factors Associated with Low e-Health Literacy and Problematic Cyberchondria Among Urban College Students

Variable		Total n (%)	Low health literacy N(%)	Moderate and High Cyberchondria (>60%) N(%)
Age	18	110 (15.6)	89 (80.9)*	5 (4.5)
	19	89 (12.6)	60 (67.4)*	10 (11.2)
	20	120 (17.0)	84 (70.0)*	13 (10.8)
	21	157 (22.2)	93 (59.2)*	19 (12.1)
	22	100 (14.2)	56 (56.0)*	13 (13.0)
	23	65 (9.2)	41 (63.1)*	6 (9.2)
	24	65 (9.2)	35 (53.8)*	13 (20.0)
Sex	Female	378 (53.5)	236 (62.4)	44 (11.6)
	Male	325 (46.0)	221 (68.0)	35 (10.8)
	Other/ Prefer not to say	3 (0.4)	1(33.3)	0 (0)
Type of College	Govt	227 (32.2)	134 (59.0)*	14 (6.2)*
	Aided	222 (31.4)	138 (62.2)*	33 (14.9)*
	Self-financing	257 (36.4)	186 (72.4)*	32 (12.5)*
Undergraduate/Postgraduate	UG	458 (64.9)	312 (68.1)*	46 (10.0)
	PG	248 (35.1)	146 (58.9)*	33 (13.3)
Year of Study	UG 1st year	164 (23.2)	117 (71.3)	11 (6.7)
	UG 2nd year	98 (13.9)	65 (66.3)	12 (12.2)
	UG 3rd year	207 (29.3)	135 (65.2)	24 (11.6)
	PG 1st year	152 (21.5)	94 (61.8)	18 (11.8)
	PG 2nd year	85 (12.0)	47 (55.3)	14 (16.5)
Field of study	Arts	167 (23.7)	107 (64.1)	15 (9.0)
	Science	383 (54.2)	250 (65.3)	42 (11.0)
	Commerce	156 (22.1)	101 (64.7)	22 (14.1)
Religion	Christian	263 (37.3)	163 (62.0)	34 (12.9)
	Hindu	389 (55.1)	262 (67.4)	42 (10.8)
	Muslim	29 (4.1)	19 (65.5)	1 (3.4)
	Other	4 (0.5)	2 (50.0)	0 (0.0)
	Prefer not to say	21 (3.0)	12 (57.1)	2 (9.5)
Place of Residence	Rural	83 (11.8)	60 (72.3)*	9 (10.8)
	Semi-urban	75 (10.6)	56 (74.7)*	10 (13.3)
	Urban	548 (77.6)	342 (62.4)*	60 (10.9)
Family Type	Nuclear	539 (76.3)	346 (64.2)	63 (11.7)
	Joint	100 (14.2)	69 (69.0)	8 (8.0)
	Single parent	49 (6.9)	31 (63.3)	5 (10.2)
	Guardian	16 (2.3)	11 (68.8)	3 (18.8)
	Orphan	2 (0.3)	1 (50.0)	0 (0)
Living arrangement	Parents/family	522 (73.9)	332 (63.6)	61 (11.7)
	Hostel	127 (18.0)	86 (67.7)	13 (10.2)
	PG/Rental	27 (3.8)	18 (66.7)	3 (11.1)
	Guardian	30 (4.2)	22 (73.3)	2 (6.7)
Perceived Economic status	Low	110 (15.6)	75 (68.2)	8 (7.3)
	Medium	582 (82.4)	377 (64.8)	68 (11.7)
	High	14 (2.0)	6 (64.9)	3 (21.4)

* Statistically significant at $p < 0.05$.

Qualitative themes and quotes



Hidden in plain sight: Suicidal behaviour among youth attending a tertiary mental health facility in Kenya

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Introduction: Suicidal behaviour, encompassing suicidal ideation, planning, and attempts, is a major public health concern among adolescents and young adults globally, with a disproportionate burden in low- and middle-income countries. Despite this, there is limited epidemiological data on the prevalence and correlates of suicidal behaviour among youth in sub-Saharan Africa. This study aimed to determine the prevalence, associated factors, and lived experiences of suicidal behaviour among youth attending a tertiary mental health facility in Nairobi, Kenya.

Methods: A convergent parallel mixed-methods study was conducted at the Youth Centre of Kenyatta National Hospital. Quantitative data were collected using a cross-sectional design with consecutive sampling of 121 participants aged 13–24 years. Sociodemographic and psychosocial data were collected alongside the Suicide Behaviors Questionnaire–Revised (SBQ-R). Qualitative data were obtained through purposive sampling of youth and caregivers using semi-structured interviews. Quantitative data were analysed using descriptive statistics, chi-square tests, and bivariate and multivariate logistic regression. Qualitative data were analysed thematically.

Results: Elevated suicide risk based on SBQ-R thresholds was identified in 34.7% of participants. Lifetime suicidality was reported by 58.7%, including suicidal ideation (58.7%), plans (35.5%), and attempts (20.7%). Past-year suicidal ideation was reported by 52.1%. After adjusting for covariates, higher education level, having children, and a positive family history of psychiatric illness were independently associated with increased suicide risk. Qualitative findings highlighted psychosocial stressors, family and peer dynamics, academic pressures, and the influence of social media as key contextual factors shaping suicidal behaviour and help-seeking.

Conclusion: Suicidal behaviour is highly prevalent among youth seeking mental health care in Kenya and is shaped by a complex interplay of demographic, familial, and psychosocial factors. These findings underscore the need for routine suicide risk screening, family-informed interventions, and youth-centred prevention strategies within mental health and primary care settings in Kenya and similar contexts.

Mental illness, incarceration, and suicide risk: Evidence from a Kenyan maximum-security psychiatry unit

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Introduction: Suicidal behaviour is substantially more common among psychiatric inpatients than in the general population, with particularly elevated risk in forensic psychiatric settings where mental illness intersects with incarceration. Despite this vulnerability, there is limited epidemiological evidence on suicidality and associated psychiatric morbidity within forensic units in sub-Saharan Africa. This study aimed to determine the prevalence of suicidal behaviour and examine associated sociodemographic and clinical factors among patients admitted to a maximum-security forensic psychiatry unit in Kenya.

Methods: A descriptive cross-sectional study was conducted at the maximum-security unit of Mathari National Teaching and Referral Hospital, Kenya. All consenting patients admitted during the study period were recruited. Psychiatric diagnoses were established using the Mini-International Neuropsychiatry Interview (MINI 5.0), while suicidal behaviour was assessed using the Suicide Behaviors Questionnaire-Revised (SBQ-R). Sociodemographic and forensic characteristics were collected using a structured questionnaire. Data were analysed using descriptive statistics and bivariate and multivariable logistic regression to identify factors associated with elevated suicide risk.

Results: Ninety-nine participants were included, of whom 92.9% were male, with a mean age of 38.1 ± 12.1 years. Lifetime suicidal ideation was reported by 35.3% of participants, while 20.2% reported at least one lifetime suicide attempt. Based on SBQ-R scores, 16.2% of patients were classified as being at high suicide risk. Psychotic disorders were the predominant psychiatric morbidity, affecting over 80% of participants, frequently co-occurring with alcohol or other substance use disorders. Lower educational attainment was significantly associated with elevated suicide risk, with participants who had only primary education showing higher odds of suicidality compared to those with tertiary education. Other factors, including age, employment status, and specific psychiatric diagnoses, showed trends toward increased risk but did not reach statistical significance after adjustment.

Conclusion: Suicidal behaviour is common among forensic psychiatric inpatients in Kenya, occurring alongside a high burden of severe mental illness, particularly psychotic disorders. Lower educational attainment emerged as a key factor associated with increased suicide risk. These findings highlight the need for routine suicide risk screening, targeted psychosocial interventions, and strengthened prevention strategies within forensic psychiatric services in low-resource settings.

Just more social: Selection effects account for key linkages between adolescents' electronic media use and externalizing behaviors

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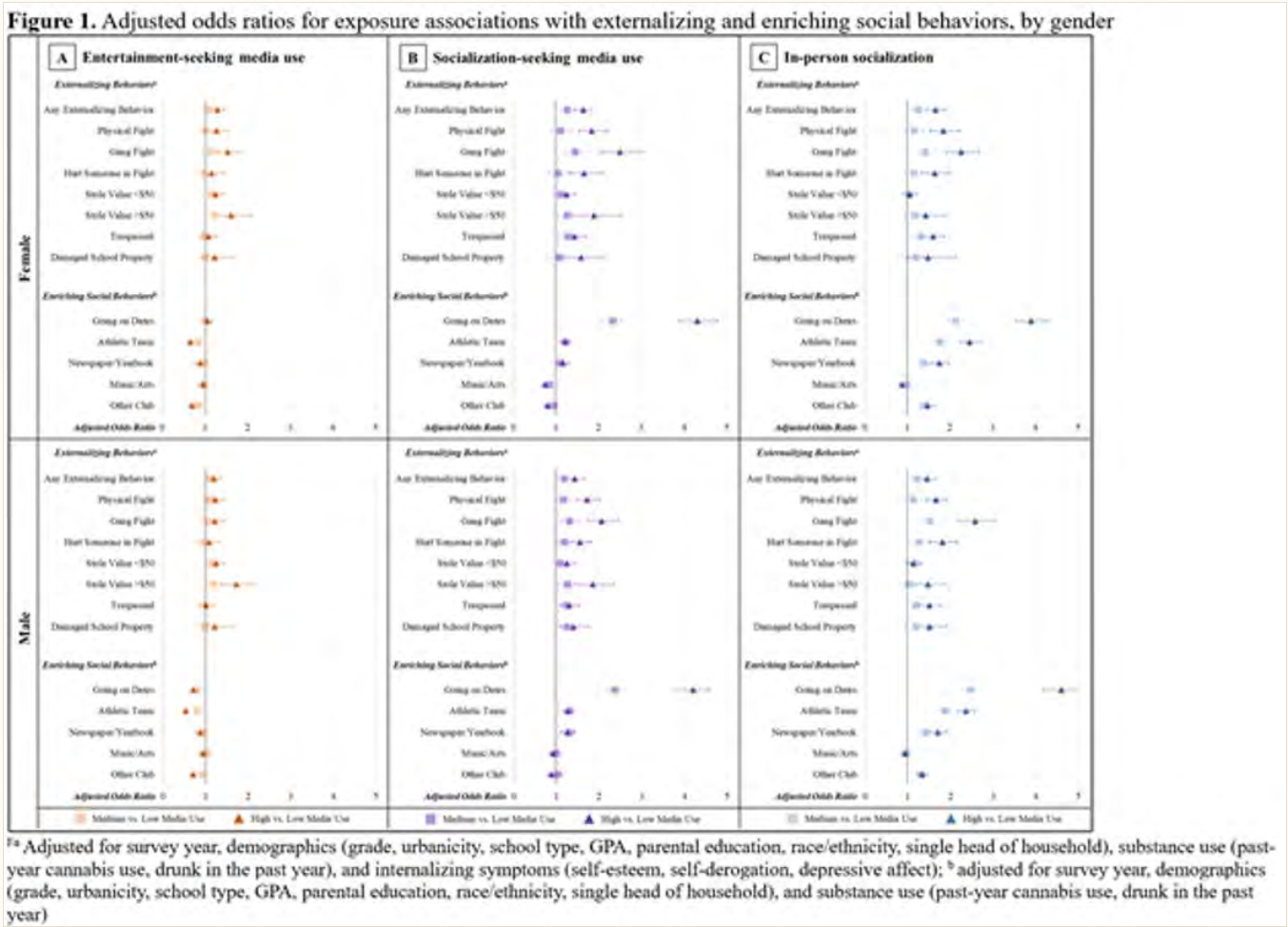
Introduction: Adolescents' electronic media use is consistently associated with externalizing behaviors (e.g., fighting with others) in observational studies; we examined whether these associations could be explained by selection effects due to an underlying propensity toward social behaviors.

Method: In a nationally representative sample of 105,397 U.S. 8th- and 10th-grade students, we conducted exploratory and confirmatory factor analyses to identify the latent factor structure of the measured electronic media use variables. Subsequently, we estimated adjusted odds ratios for the associations of two empirically distinct categories of adolescent electronic media use—entertainment-oriented media use (video streaming, video gaming) and socialization-oriented media use (social media, video chatting, texting, talking on the phone) with externalizing behavioral outcomes using sex-stratified logistic regressions. As a comparison, we also estimated adjusted odds ratios for the associations of adolescent in-person socialization with externalizing behaviors.

Results: The results showed a remarkable resemblance of the associational patterns for socialization-oriented media use and in-person socialization with externalizing behaviors, while associations for entertainment-oriented media use were markedly lower/null. To illustrate, for adolescent females, high (vs. low) levels of socialization-oriented media use and of in-person socialization were associated with 1.64 (95% CI: 1.45, 1.86) and 1.66 (95% CI: 1.46, 1.90) times the odds of having been engaged in any externalizing behavior, respectively. In contrast, a high (vs. low) level of entertainment-oriented media use was associated with only 1.30 (95% CI: 1.14, 1.48) times the odds of engaged in any externalizing behavior for adolescent females. For adolescent males, high (vs. low) levels of socialization-oriented media use and of in-person socialization were associated with 1.43 (95% CI: 1.23, 1.66) and 1.46 (95% CI: 1.27, 1.67) times the odds of having engaged in any externalizing behavior, respectively; a high (vs. low) level of entertainment-oriented media use was associated with only 1.20 (95% CI: 1.07, 1.36) times the odds of having engaged in any externalizing behavior.

Conclusion: Electronic media use is not per-se associated with externalizing behaviors, but an inclination toward social behaviors among some adolescents—both in digital and in-person settings—may represent an uncontrolled selection effect in previously observed media use-externalizing associations.

Adjusted odds ratios by gender



Long life but high suicide rates in old males of Sardinia's blue zone: The role of subthreshold / transdiagnostic mood disorders according to a sociobiological perspective

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Background: Sardinia's Blue Zone is recognized for exceptional longevity and healthy ageing. Paradoxically, the area reports the highest suicide rates among older men in Italy. Although depression is a major clinical predictor of suicide, it remains unclear whether this paradox reflects a greater burden of depressive disorders or alternative transdiagnostic and sociocultural mechanisms. This study compared depressive episodes, suicidal ideation, and subthreshold depressive symptoms among older adults living in the Blue Zone and elsewhere in Sardinia.

Methods: A secondary cross-sectional analysis was conducted using data from a population-based survey of Sardinian residents aged ≥ 60 years. The study included 432 community-dwelling older adults, of whom 53 lived in the Blue Zone and 379 in the remaining Sardinian provinces. Depression and suicidal ideation were assessed using the Patient Health Questionnaire-9 (PHQ-9). Differences between the Blue Zone and the remaining Sardinian provinces were analysed by sex using χ^2 tests, one-way ANOVA, and odds ratios with 95% confidence intervals.

Results: Depressive episodes tended to be less frequent in the Blue Zone than in the remaining Sardinian provinces, although the difference did not reach statistical significance. Likewise, no significant differences were observed in mean PHQ-9 scores or suicidal ideation. The only statistically significant finding concerned subthreshold depressive symptoms among older men, which were markedly more frequent in the Blue Zone than in the rest of Sardinia (21.0% vs. 2.3%; OR 11.13, 95% CI 2.5–49.1). Conversely, women in the Blue Zone had a lower prevalence of subthreshold depressive symptoms than women in the remaining Sardinian provinces (14.7% vs. 37.0%), although this difference was not statistically significant.

Conclusions: The absence of significant differences in depressive episodes or suicidal ideation, despite the known excess of suicide among older men in Sardinia's Blue Zone, suggests that conventional clinical indicators may not fully account for the epidemiological paradox observed in this population. The higher prevalence of subthreshold depressive symptoms among older men supports further investigation of transdiagnostic, sociocultural, and sociobiological mechanisms potentially contributing to suicide risk. From a public health perspective, these findings support broader epidemiological models integrating psychiatric, sociological, and biological determinants to improve suicide prevention in long-lived populations.

Subthreshold depressive symptoms by sex

Table 1. Prevalence of subthreshold depressive symptoms (PHQ-9 score 5–9) by sex in the Blue Zone and the remaining Sardinian provinces

Sex	Blue Zone n/N (%)	Other Sardinian Provinces n/N (%)	Odds Ratio (95% CI)	p value
Women	5/34 (14.7%)	77/208 (37.0%)	2.14 (0.8–5.7)	0.340
Men	4/19 (21.0%)	4/171 (2.3%)	11.13 (2.5–49.1)	0.001

Note. PHQ-9 scores of 5–9 indicate subthreshold depressive symptoms. Odds ratios (ORs) and 95% confidence intervals (CIs) are reported as in the original analysis. Yates correction was applied; Fisher's exact test was used for women.

Maternal diabetes during pregnancy and offspring depression: A nationwide register-based study

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Introduction: Limited studies have examined the association between maternal diabetes during pregnancy and offspring depression, are mostly based on small sample sizes. We aim to examine the association between maternal diabetes during pregnancy and offspring depression. We hypothesize that maternal diabetes during pregnancy increases the risk for offspring depression.

Method: This nationwide register-based study was based on a nested case-control study design. It utilized several Finnish national registers to collect the information on the cases (37,677), the controls (145,068), and their parents. Conditional logistic regression models were used to examine the association between maternal diabetes and depression, adjusting for several potential covariates (maternal age, parity, SES, and psychopathology, as well as gestational age and weight of the offspring). The potential covariates were tested using the Pearson's chi-square test for categorical covariates and t test for continuous covariates for the association with exposures among controls. The association between maternal diabetes and offspring depression was additionally studied by stratifying by biological sex.

Results: Maternal diabetes during pregnancy was associated with offspring depression (aOR 1.34 (1.26-1.44)). When the association was stratified by biological sex, associations were found among both girls (aOR 1.39, 95% CI 1.28-1.52) and boys (aOR 1.27, 95% CI 1.13-1.42). The associations were found also in different depression diagnose ages in off-springs as follows: at 5-12 years (aOR 1.49, 95% CI 1.26-1.77), 13-18 years (aOR 1.39, 95% CI 1.27-1.51) and 19-25 years (aOR 1.20, 95% CI 1.05-1.36).

Conclusion: Children born to mothers who experienced diabetes during pregnancy exhibited a higher risk of developing depression later in life. This association highlights the potential long-term mental health consequences of prenatal metabolic exposure and emphasizes the need for early depression screening.

Mental health of university students: Results from the development and implementation of a pragmatic university mental health services model in Southwest Nigeria (PRUMES) study

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Introduction: The period when individuals are engaged with university education is a time of heightened risk for mental health conditions, and its associated disability, poor educational performance and loss of productivity. There is a dearth of quality epidemiological studies of university students' mental wellbeing in low- and middle-income countries.

Method: Using proportional sampling, data was obtained from 2,993 students from Fountain University, Lagos State University and University of Ibadan (all in southwest Nigeria), using the 12-item General Health Questionnaire, Rosenberg Self Esteem Questionnaire and Duke-UNC Functional Social Support Questionnaire (FSSQ).

Results: Majority of the students were younger than 25 years (81.1%) and were undergraduates (82.5%). Three fifths of the students were female; one fourth of them had witnessed a physical fight between their parents and more than half had gone to bed hungry before due to lack. Mean score on functional social support and self-esteem scales were 33.2±6.9 and 19.8±4.3 respectively.

The prevalence of psychological distress for the entire sample was 40.6%. Factors associated with the occurrence of psychological distress included being undergraduate (OR = 1.59; 95% CI: 1.11-2.19), being female (1.23; 1.04-1.44), younger age (i.e., age 20-24 years compared to 25+ years) (1.58; 1.14-2.19), single parent upbringing (1.24; 1.00-1.54) or upbringing by others (1.44; 1.04-2.00), poor social support (2.03, 1.73-2.39) and low self-esteem (2.33, 1.99-2.74). Exposure to food insecurity was associated with the presence of psychiatric morbidity in a dose dependent fashion (rare exposure 1.22; 1.03-2.27; more frequent exposure 2.27; 1.78-2.88). Absence of maternal formal education was protective against psychological distress in the student (0.35; 0.18-0.69).

Conclusion: The high prevalence of psychiatric morbidity and its relationships with demographic, family and university-related factors among university students in southwest Nigeria is wake up call to policy makers and university administrators to invest in the mental wellbeing of university students, paying particular attention to modifiable risk factors and early recognition and treatment of common mental disorders.

Paranoia and socioeconomic factors: A clinical study

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Background: Paranoia is a complex, transdiagnostic psychopathological phenomenon characterized by mistrust, suspiciousness, and threat-related interpretations in interpersonal relationships. Its clinical expression may be shaped by individual vulnerabilities, relational experiences, social conditions, and contextual factors. Although previous studies have linked paranoid ideation to socioeconomic disadvantage, social isolation, childhood trauma, and substance use, these associations remain less extensively investigated in clinical psychiatric samples.

Objectives: This study examined the association between paranoid severity, measured using the Ferrara Worry Questionnaire total score, and individual, clinical-social, and municipal socio-territorial indicators in a clinical population with psychiatric disorders. The aim was to identify the factors most strongly associated with variability in paranoid symptomatology from a dimensional and transdiagnostic perspective.

Methods: A cross-sectional observational study was conducted on 70 adults with a psychiatric diagnosis, recruited from the Psychiatric Inpatient Unit of Cona Hospital between February 2024 and January 2026. Paranoid severity was assessed using the Ferrara Worry Questionnaire (FWQ). Data were collected on childhood trauma, substance use, cannabis use, employment status, education, and other clinical-social variables. Individual data were integrated with municipal indicators of population density, socioeconomic deprivation, educational deprivation, economic inequality, and migrant population density. Associations were explored using Spearman correlations and non-parametric tests. A Bayesian regression model with Student-t likelihood was estimated, followed by sensitivity analysis adjusted for age and sex.

Results: FWQ scores were available for 70 participants, but territorial analyses with complete data included 62 participants. None of the municipal indicators showed a significant association with paranoid severity. At the individual level, substance use history was associated with higher FWQ scores. In the Bayesian model, substance use was associated with an estimated mean increase of 26.86 points, with a 95% credible interval of 11.05 to 42.44, and remained stable after adjustment for age and sex. Non-employment showed a weaker and more uncertain association. The cannabis-related signal was preliminary because of the small subsample.

Conclusions: Substance use history showed the most robust association with greater paranoid severity. These findings support dimensional assessment of paranoia and suggest integrating symptom evaluation with substance use and social functioning.

Parental serious mental illness and risk of severe childhood infections: A nationwide population-based cohort study

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Introduction: Parental serious mental illness (SMI) has been associated with adverse developmental and psychiatric outcomes in offspring, but its relationship with common childhood infections remains poorly understood. Whether parental SMI increases children's susceptibility to infection or primarily influences progression to more severe illness has not been established. We examined the association between parental SMI and infection outcomes during the first five years of life.

Methods: Using linked nationwide administrative databases in Taiwan, we assembled a retrospective birth cohort of 1,999,322 singleton children born between 2004 and 2014. Parental SMI, including schizophrenia, bipolar disorder, and major depressive disorder, was treated as a time-varying exposure. Childhood outcomes included medically attended diarrhea and respiratory infections, antibiotic-treated infections, and infection-related hospitalization. Poisson regression with generalized estimating equations was used to estimate adjusted incidence rate ratios (aIRRs) and 95% confidence intervals (CIs). Additional analyses evaluated differences according to the affected parent, timing of parental diagnosis, and psychiatric diagnosis.

Results: Almost all children (95%) experienced at least one medically attended infection before age five. Overall infection rates were similar between exposed and unexposed children (aIRR 1.01, 95% CI 1.01–1.01). In contrast, parental SMI was associated with modestly higher rates of antibiotic-treated infections (aIRR 1.04, 95% CI 1.03–1.05) and substantially higher rates of infection-related hospitalization (aIRR 1.31, 95% CI 1.29–1.33). Hospitalization risk was greatest among children with SMI in both parents, followed by maternal and paternal SMI. Associations were stronger when maternal SMI preceded childbirth and were generally more pronounced for schizophrenia and bipolar disorder than for major depressive disorder.

Conclusion: Parental SMI was associated with increased severity of childhood infections rather than a higher overall frequency of infection events. These findings suggest that parental mental illness may identify families in which children are at greater risk of severe infectious illness and support integrating parental mental health into pediatric risk assessment and preventive care.

Post-traumatic stress disorder in older Canadian adults: Analysis of risk and protective factors

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Introduction: Post-traumatic stress disorder (PTSD) is a significant public health concern affecting at least 1.5–4% of older adults. Age-related changes in physical function, and social networks may exacerbate symptoms and compound with comorbidities, leading to reduced quality of life and increased healthcare utilization. Better understanding of the development of PTSD requires examining traumatic exposures such as military service, childhood trauma, and traumatic brain injury, alongside potential protective factors including physical activity and social support.

Methods: This cross-sectional study analyzed data from the Comprehensive and Tracking arms of the Canadian Longitudinal Study on Aging (CLSA) (N = 51,338). Associations for traumatic stressors, potential protective factors, functional impairment, and healthcare utilization with PTSD status were tested in sample-based, weighted, and sex-stratified multivariable logistic regression models adjusted for age, sex, sexual orientation, income, and education level.

Results: Across both arms, participants with PTSD were younger, with a higher proportion reporting income <\$20,000. Weighted and unweighted models were consistent. In weighted models, all risk factors examined such as parental death/illness and emotional abuse (OR Comprehensive: 1.39, 95%CI: 1.14–1.70; OR Comprehensive: 1.70, 95%CI: 1.42–2.03 respectively) were associated with higher odds of PTSD, except for parental divorce/separation and physical abuse. Physical activity was not significantly associated with PTSD after adjustment ($p > 0.05$), while social supports showed marginal protective effects ($p < 0.05$). PTSD was associated with greater functional impairment (OR Comprehensive: 2.11, 95%CI: 1.71–2.61), and higher healthcare utilization, including visits to specialists, psychologists, emergency departments and social work ($p < 0.05$). Sex-stratified analyses showed mostly consistent findings, though veteran status and family physician visits were significantly associated with PTSD among males only.

Conclusion: PTSD in older adults was associated with multiple traumatic exposures, functional impairment and increased healthcare utilization. The lack of protective effects of physical activities and social supports in this analysis may reflect the multifaceted nature of resilience, where socioeconomic factors may limit protective effects within this population, with further research needed to clarify these relationships. This underscores the impact of PTSD on wellbeing and healthcare burden among community-dwelling older adults in the CLSA, emphasizing the importance of tailored prevention and intervention strategies.

Psychophysical well-being and eating patterns in a sample of schizophrenic and bipolar patients with metabolic syndrome: A case-control study

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Introduction: Individuals with severe mental illnesses experience premature mortality, largely due to cardiovascular disease and diabetes. Metabolic syndrome (MetS) is a clinical predictor of these conditions and is strongly associated with the use of second-generation antipsychotics (SGA). This is compounded by at-risk lifestyles, such as poor dietary habits. This study aimed to evaluate the clinical, metabolic, and dietary differences between schizophrenic and bipolar patients with and without MetS.

Method: Schizophrenic or bipolar patients aged 18 to 65 years, and treated with SGA for at least one year were recruited. Blood samples were collected from patients. Illness and symptoms severity, general functioning, health status, sleep and overall quality of life were evaluated. Moreover, participants completed a dietary diary.

Results: Twenty-five patients with MetS (MetS+) and twenty-five without MetS (MetS-) were recruited (56% male; mean age = 47.36, SD=11.01; mean education years = 11.54, SD=3.77). The two groups were homogeneous for gender, age, education, diagnosis, physical activity, number of hospitalizations, marital status, occupational status, and living arrangements ($p > .05$). Eighty-two percent of participants did not engage in regular physical activity. Compared to MetS-, MetS+ group showed significantly higher BMI ($p < .001$), illness severity (CGI, $p = .021$), and depression (BPRS item, $p = .008$). Regarding metabolic and biological markers, significant differences were found for glycosylated haemoglobin ($p = .009$), fasting plasma glucose ($p = .004$), triglycerides ($p = .006$), HDL ($p = .005$), lipoprotein(a) ($p = .034$), adiponectin ($p = .025$), and P-selectin glycoprotein ($p = .05$). Bromatological analysis of dietary diaries revealed no significant differences in macronutrient intake between groups. According to the national nutritional guidelines, and irrespective of MetS status, patients exhibited excessive intake of simple sugars (>13% of total kcal) and saturated fatty acids (>10% kcal), and deficits in dietary fiber (~16.6g/day) and polyunsaturated fatty acids (PUFAs, <4% kcal).

Conclusion: Both groups showed an unhealthy diet and sedentary lifestyle. The MetS+ group differs by higher illness severity, depressive symptoms, and a biomarkers profile characterized by suppressed adiponectin and elevated P-selectin glycoprotein, suggesting adipose tissue dysfunction and endothelial activation, respectively. Clinical management should include integrated interventions targeting healthy lifestyles.

PTSD and exposure to violence among people with experience of prostitution in France: A participatory mixed-methods study

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Key words: Prostitution, Post-Traumatic Stress Disorder, Violence, Mental Health

Introduction: Mental health problems are prevalent among people living with or having, lived, experienced of prostitution (PLP), with violence consistently identified as a key correlate. However, few studies have examined PTSD specifically using validated instruments. The experience of violence, whether throughout a person's life or in the context of prostitution, is often assessed using binary indicators that do not always distinguish between the type, context or frequency of the violence.

Methods: We conducted a participatory mixed methods study co-developed with PLP and two nonprofit organizations. Quantitative data were collected through a questionnaire completed by PLP (n= 258) across more than 20 French cities, among a predominantly migrant sample. Multivariable logistic regression was used to examine factors associated with probable PTSD (PCL-5 ≥ 33). This was complemented by semi-structured interviews with PLP (n=20) and social support providers (n=25). Integration followed a complementary mixed methods 'following a thread' approach, using quantitative results to guide qualitative exploration and interpretation.

Results: Nearly two thirds of participants screened positive for probable PTSD (62%). Several factors were independently associated with increased odds: having experienced sexual violence outside of prostitution (aOR = 2.33; 95% CI: 1.16–4.72), high levels of violence exposure within prostitution (aOR = 2.75; 95% CI: 1.33–5.82), and a greater number of self-reported health conditions (aOR = 1.66; 95% CI: 1.25–2.28). Conversely, living with at least one child (aOR = 0.37; 95% CI: 0.17–0.76) and having left prostitution (aOR = 0.23; 95% CI: 0.08–0.58) were both associated with reduced odds. The qualitative component highlighted how violence accumulates across the life course and leaves enduring psychological consequences.

Conclusion: These findings extend the evidence base on trauma-related mental health outcomes among PLP by providing France-specific estimates of probable PTSD, and by identifying violence exposures, both within and outside prostitution, as distinct, independent correlates.

Seasonal peak timing of suicide-related emergency department visits by age group in 23 U.S. States, 2010–2019

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Introduction: Understanding the seasonal distribution of suicide-related visits to emergency departments (EDs) helps ensure that resources are available at times of high volume and patients have maximal access to care. Research has demonstrated regular seasonal patterns of deaths by suicide, which vary across developmental period and sex and are in part linked to school calendars and temperature. However, it is unclear how seasonality patterns generalize to non-fatal suicidal ideation and attempts that result in ED visits.

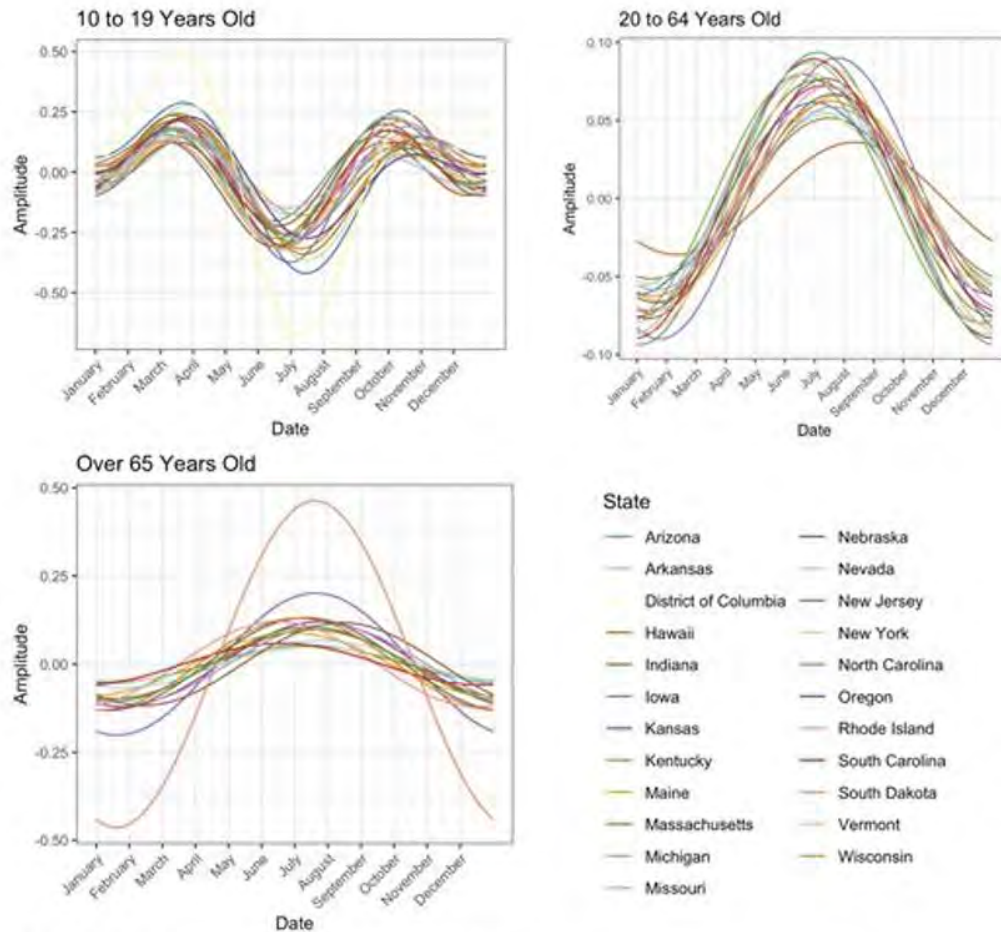
Methods: We identified visits for intentional self-harm or suicide-related visits to EDs from 23 states in the State Emergency Department Databases (SEDD). We used harmonic regression models to estimate per capita visit rates each month in each state and the peak timing of visits. We also investigated potential associations between the timing of seasonal peaks and state-level temperature data using unadjusted linear regression models.

Results: We identified significant seasonal variation in suicide and intentional self-harm related ED visits, particularly among youth aged 10–19 years, with differing patterns from adults. A bimodal relationship with peaks in the spring and fall fit youth ED visits, whereas a unimodal model fit adult ED visits, with a peak in the summer. There was no variation by sex within each age group. Seasonal peak timing was similar among states across the country; however, there was an association by state between higher temperatures and earlier peaks for youth and adults.

Discussion: Peak youth suicidality coincides with the spring and fall terms of the academic calendar. In contrast, suicide-related ED visits among adults peak during the summer and may be driven by changes in routines or responsibilities. These periods are key times for implementing targeted interventions for adolescents and young adults through schools in addition to adults through primary care, as well as increasing mental health resources in emergency departments.

Harmonic models of state-level rates by age group

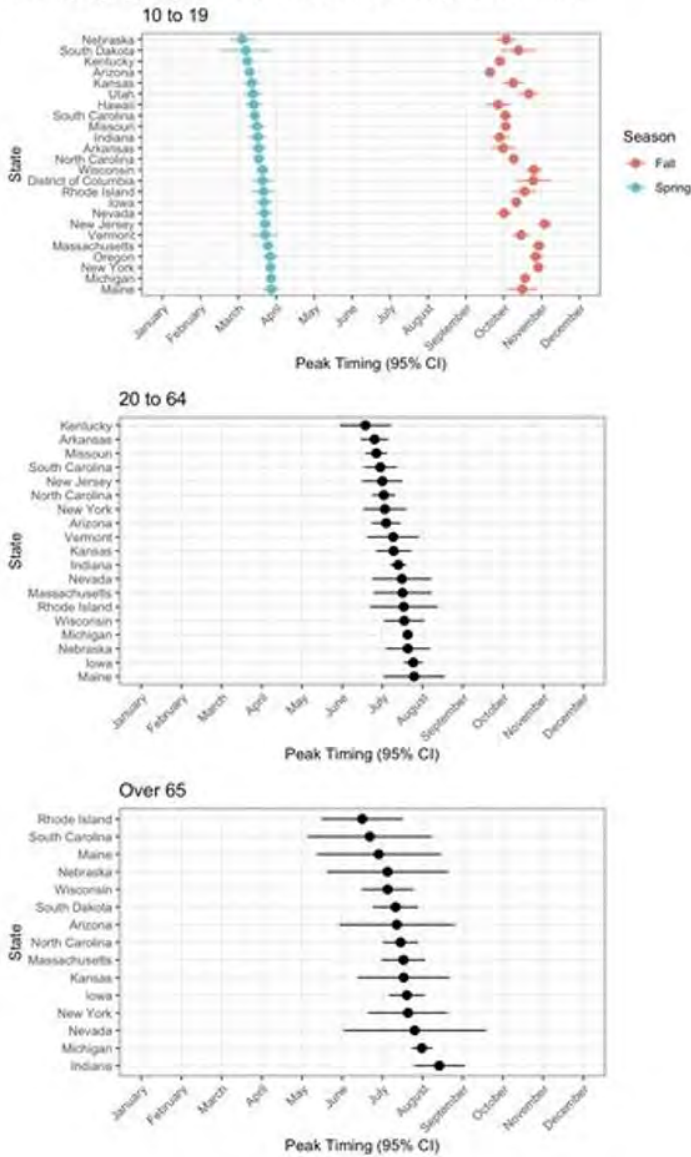
Figure 3. Harmonic Models of state level rates of suicide related ED visits by age group (10-19, 20-64, 65+) among 23 US States



*Only includes states where there was a statistically significant harmonic component. The following states did not have a harmonic component for the given age group. 10-19: None, 20-64: South Dakota, District of Columbia, Oregon Over 65: Missouri, District of Columbia, Oregon, Arkansas, Vermont, Utah, New Jersey, Kentucky, Hawaii

Estimated peaks by age group

Figure 4. Estimated peaks and 95% confidence interval of state level rates of suicide related ED visits by age group (10-19, 20-64, 65+) among 23 US States



* Only states and age groups with statistically significant seasonality were reported.

Sex-specific associations between depression and BMI: Results from three national representative surveys

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Background: The relationship between Body Mass Index (BMI) and Major Depressive Episodes (MDE) is well-documented. These associations have been shown to vary by sex, though not consistently across studies. Here we further investigate sex-specific patterns and examine whether exposure to childhood adversities (CA) influences the association between BMI and MDE among men and women.

Methods: Data were drawn from the 2005, 2010, and 2017 nationally representative cross-sectional French Health Barometer surveys. Logistic regressions were performed to examine whether exposure to CAs influences the association between BMI categories and 12-month MDE (n=47,542) in the overall sample, then among females and males, adjusting for age, socioeconomic indicators, and survey wave.

Results: The overall prevalence of MDE among BMI groups displays a U-shaped association: 12.9% in underweight adults, 9.0% in normal weight, 7.3% in overweight and 10.6% in adults with obesity. In the overall sample, multivariable models adjusting for key sociodemographic variables showed a strong association of female sex (AOR=2.07, 95% CI 1.94-2.22), exposure to CAs (AOR=1.89, 95% CI 1.76-2.02), underweight (AOR=1.18, 95% CI 1.03-1.37) and obesity (AOR=1.28, 95% CI 1.16-1.41) with MDE. There was a strong sex x BMI interaction (p=0.002), however, no significant CA x BMI interaction was found. In analyses stratified by sex, multivariable models revealed that underweight was significantly associated with MDE among males (AOR=1.83, 95% CI= 1.26-2.66) but not among females (AOR=1.07, 95% CI= 0.89-1.28). Obesity was also significantly associated with MDE in both females (AOR=1.31, 95% CI= 1.16-1.49) and males (AOR=1.22, 95% CI= 1.02-1.47).

Conclusions: The findings support a differential association between BMI and MDE in males and females, and provide no evidence that CA exposure is a significant effect modifier in the association between BMI and MDE in men and women.

The prevalence of anxiety, depression and psychological stress among older adults in Southeast Asia: A systematic review and meta-analysis

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Background: This systematic review estimated the prevalence and moderators of depression, anxiety, and psychological stress among older adults in Southeast Asia.

Methods: PubMed, PsycINFO, Scopus, Web of Science, and IMSEAR were searched from inception to March 2026 for observational studies. Eligible studies used validated screening or diagnostic tools to assess depression, anxiety, or stress among adults aged ≥ 60 years in the ten World Health Organization Southeast Asia countries. Two reviewers independently screened studies, extracted data, and assessed quality using the Joanna Briggs Institute checklist. Pooled prevalence estimates were calculated using random-effects meta-analysis. Subgroup analyses and meta-regression explored heterogeneity and moderators of prevalence.

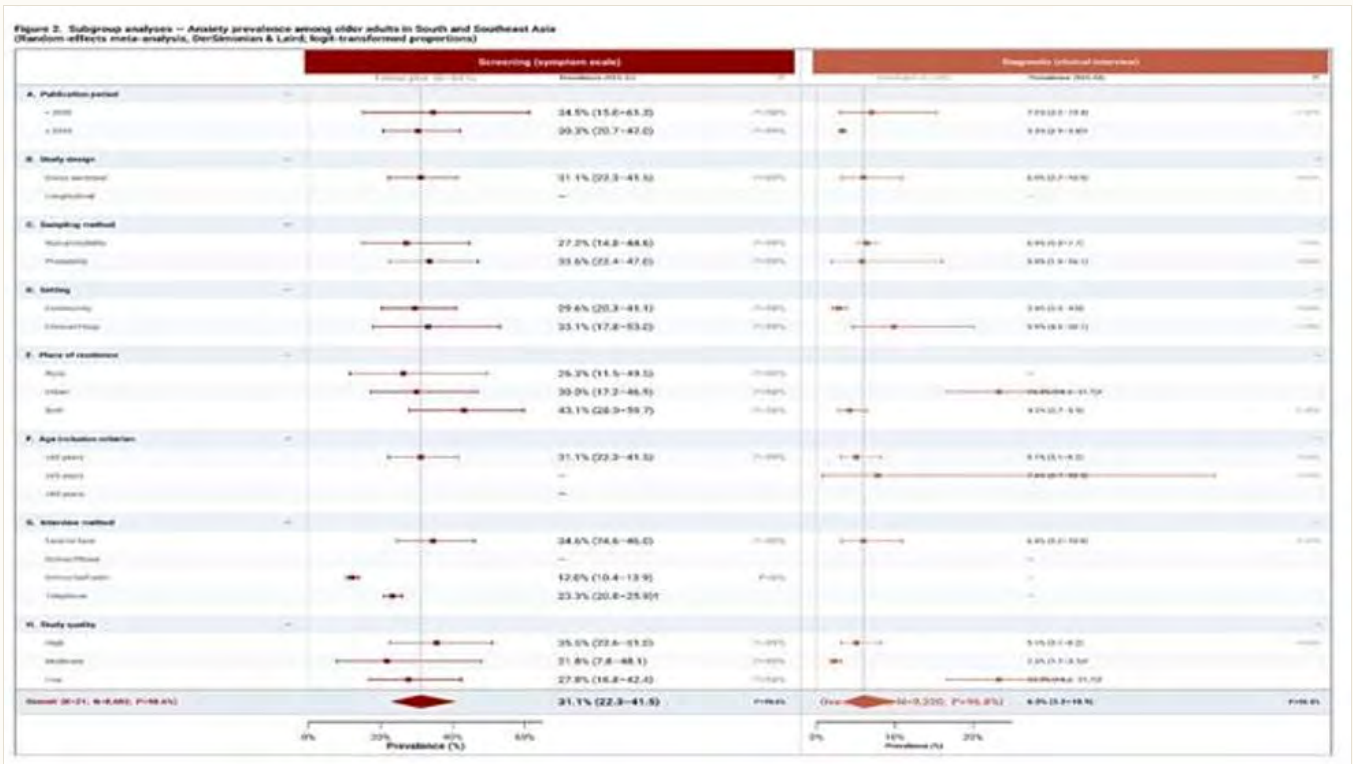
Results: From 13,525 citations, 7,398 studies were screened after duplicate removal, and 139 studies on depression (441,292 participants), 23 on anxiety (17,922 participants), and 18 on stress (10,867 participants) from eight countries were included. Overall, participants had a mean age of 71 years (SD 3.9), and 55.0% were female. Pooled prevalence based on clinical symptoms was 34.5% for depression (95% CI 32.6–36.5; $I^2 = 98.3\%$), 31.1% for anxiety (95% CI 22.3–41.5; $I^2 = 98.6\%$), and 34.4% for stress (95% CI 25.7–44.3; $I^2 = 98.9\%$). Lower prevalence estimates based on clinical diagnosis included 12.5% for depression (95% CI 11.1–14.1; $I^2 = 98.7\%$) and 6.0% for anxiety (95% CI 3.2–10.9; $I^2 = 96.8\%$); No studies reported clinical diagnoses of stress. Depression and anxiety were higher among females than males for both clinical symptoms and diagnoses, whereas perceived stress was higher among males. In multivariable meta-regression, heterogeneity was substantially reduced for diagnostic outcomes, including depression (female sex, study quality, publication year, and country; $R_p^2=70.2\%$), anxiety (age and study quality; $R_p^2=80.2\%$), and perceived stress (female sex and publication year; $R_p^2=47.9\%$), while no reduction was observed for clinical symptoms of depression and anxiety.

Conclusion: Depression, anxiety, and stress are highly prevalent among adults aged 60 years and older in Southeast Asia, with approximately one-third screening positive for clinically relevant symptoms. Diagnostic estimates were lower but still indicated substantial unmet mental health needs. Strengthening integrated mental health services for older adults in Southeast Asia should remain a public health priority.

Depression prevalence subgroup analyses

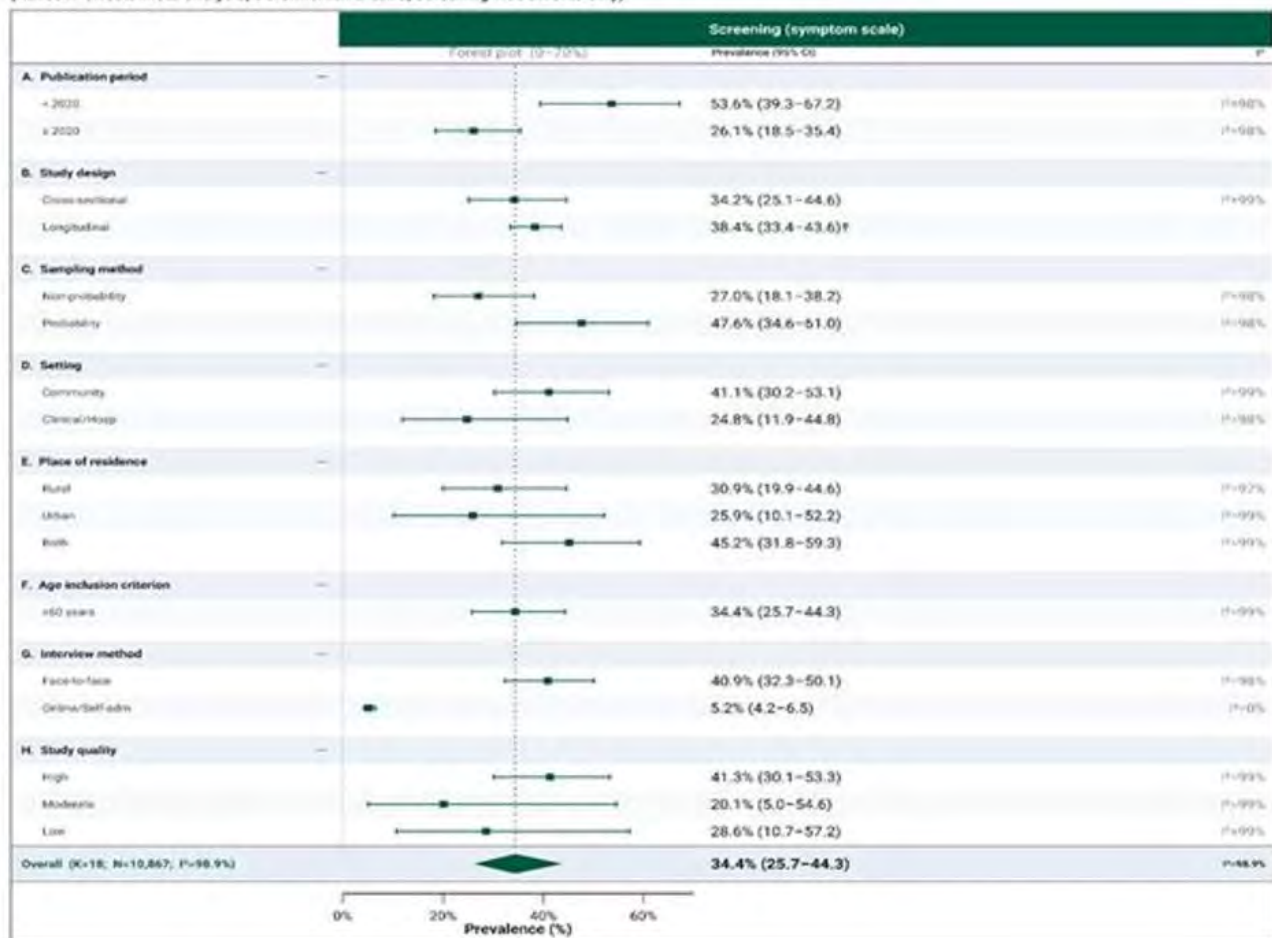


Anxiety prevalence subgroup analyses



Perceived stress prevalence subgroup analyses

Figure 3. Subgroup analyses – Perceived stress prevalence among older adults in South and Southeast Asia (Random-effects meta-analysis, DerSimonian & Laird; screening instruments only)



The science of child and adolescent mental health in Brazil: A nationwide systematic review and compendium of evidence-based resources

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Introduction: Brazil is home to 50 million children and adolescents whose mental health needs require context-sensitive research, which remains scattered and not comprehensively evaluated as a collective body of evidence.

Methods: We systematically reviewed prevalence estimates, assessment instruments, and interventions for child and adolescent mental health in Brazil (PROSPERO: CRD42023491393). We searched international (PubMed, Web of Science, PsycINFO, Google Scholar) and national (SciELO, LILACS, Brazilian Digital Library of Theses and Dissertations) databases up to July 2024. Data extraction, quality assessment and reporting followed COSMIN and Cochrane guidelines.

Results: We synthesized data from 734 prevalence studies, 912 assessment instruments, and 173 intervention trials. The prevalence of any mental disorder ranges from 10.8% to 19.9%, and notably, no nationally representative study exists. Epidemiological surveillance data revealed a stark increase in self-harm, reaching 133.1 per 100,000 in 2019 for ages 10-19 years old. Indigenous youth face suicide rates are 17 times higher than national averages, reaching 11 per 100,000 for ages 10-14 years old. Severe violence exposure is highly prevalent (21% of adolescents reported domestic physical violence in the previous month), disproportionately impacting Black youth. Furthermore, most assessment instruments were foreign-developed and lacked adequate local translation and psychometric or cross-cultural validation. Interventions in general remain under-implemented. The largest trials evaluated foreign, high-income country substance-use prevention programs that have already proved ineffective locally. Finally, research funding is primarily state-driven, and output remains heavily centralized in the wealthier an whiter Southern and Southeastern states, with a critical lack of data on Indigenous, Quilombola, and Black populations.

Conclusions: This systematic review contributes to the debate on how Brazil's socio-cultural challenges affect youth mental health, emphasizing systemic racism and regional differences on violence exposure, suicide rates and resource allocation. Brazilian research heavily relies on international perspectives with inadequate localization, misrepresenting national context. Public funding must target these historical inequities by prioritizing culturally and context relevant local research.

Funding: The Stavros Niarchos Foundation.

Weight status, bullying, mental health and academic performance among Jordanian adolescents: A cross-sectional structural equation modelling study

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Introduction: Adolescent obesity is commonly treated as a physical health issue, but its consequences may extend to peer victimization, psychological distress, school experience, and academic performance. Evidence from Middle Eastern adolescent populations remains limited. This study examined the relationships between weight status, bullying, anxiety, depression, school experience, and academic performance among adolescents in Jordan.

Method: A cross-sectional study was conducted among 812 Jordanian adolescents aged 11-18 years recruited from public schools and pediatric outpatient clinics. Weight status was classified using body mass index. Participants completed a structured questionnaire covering demographic characteristics, lifestyle factors, bullying, school experience, and academic performance. Anxiety was assessed using the Generalized Anxiety Disorder-7 scale, depressive symptoms using the Patient Health Questionnaire-9 and Short Mood and Feelings Questionnaire. Structural equation modelling was performed in R using the lavaan package and the WLSMV estimator to examine direct and indirect pathways among weight status, bullying, mental health, school experience, and academic performance, with socioeconomic and demographic variables included as predictors of academic performance.

Results: The sample included 812 adolescents; 63.1% were female, 128 were classified as obese, 123 as overweight, and 31 as underweight. Bullying was reported by 54.3% of adolescents with obesity compared with 20.1% of those with normal weight ($p<0.001$). The SEM showed acceptable fit ($CFI=0.90$, $TLI=0.96$, $RMSEA=0.08$, $SRMR=0.02$). Higher weight status predicted bullying ($\beta=0.269$, $p=0.009$), and bullying predicted higher anxiety ($\beta=0.283$, $p<0.001$). Anxiety and depression were associated with poorer school experience ($\beta=-0.153$, $p=0.037$; $\beta=-0.305$, $p<0.001$, respectively). Higher weight status also had a direct negative association with academic performance ($\beta=-0.123$, $p=0.009$). Parental education and household income were positively associated with academic performance.

Conclusion: In this Jordanian sample, higher weight status was linked to bullying, poorer mental health-related school experience, and lower academic performance. Obesity prevention strategies for adolescents should move beyond weight reduction and include anti-stigma, anti-bullying, mental health, and school-based equity components.

What do we know about depression among agricultural workers? A scoping review of prevalence and determinants

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American University of Beirut, Lebanon

Background: Depression, characterized by persistent sadness, loss of interest, and poor concentration, can severely impair an individual's ability to work, learn, and live. Globally, 5.7% of adults live with depression, making it a leading cause of disability, premature death, and a major contributor to suicide. Farmers and agricultural workers are consistently identified as a high-risk group for depression. Existing systematic and scoping reviews on this population have identified a broad range of factors associated with mental health problems. However, those reviews often combine multiple mental health outcomes together as a single unit, focus on limited geographical regions, or examine chemical or nonchemical stressors in isolation, limiting disorder-specific insights.

Objective: This scoping review aims to comprehensively map global epidemiological evidence on depression as a mental health outcome among farmers and agricultural workers, emphasizing determinants across the life course.

Methods: The review will follow Joanna Briggs Institute methodology and PRISMA-ScR guidelines. Population-based epidemiological studies (cross-sectional, case-control, cohort) will be included, without restrictions on publication year or language. MEDLINE, APA PsycInfo, and Embase will be searched using a strategy developed with the help of a medical librarian and a mental health epidemiologist. Grey literature will also be screened.

Two independent reviewer pairs will conduct title/abstract and full-text screening following calibration exercises (Cohen's $k \geq 0.90$). A PRISMA flow diagram will show the detailed selection process.

Data charting will extract detailed information on study design, country, type of farmers/agricultural workers (for example: dairy, poultry, crop), sample size, data collection method, participant characteristics, confounders, direct and indirect pesticide exposure assessment and/or social stressors assessment, analytical approaches, and depression assessment method (for example: structured clinical interview, self-report).

Expected Outcomes and Relevance: The review will (1) summarize depression prevalence, (2) catalogue studied risk and protective factors, (3) visualize geographic and temporal trends, (4) identify the journals and most prolific authors and (5) map co-occurrence of pesticide exposure and social stressors indicators using VOSviewer. In conclusion, this scoping review of depression determinants among farmers/agricultural workers will showcase the interconnectedness of multiple determinants. Consequently, it will identify gaps and inform future research on depression among this population.

When hospitalisation and mortality tell different stories: Trends in self-harm and suicide among Australian youth

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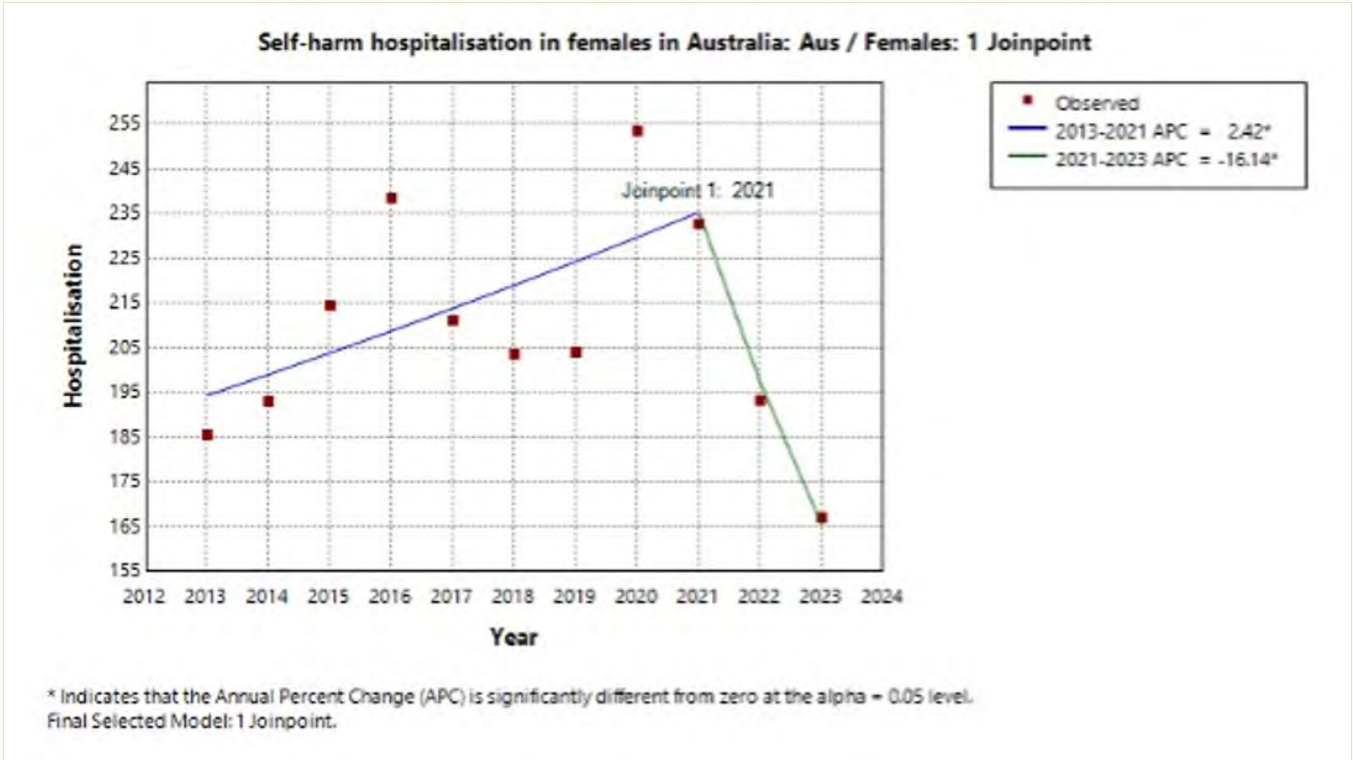
Introduction: Hospital-treated self-harm and suicide mortality are widely used population-level indicators for monitoring suicide risk and informing suicide prevention strategies¹⁻³. However, it remains unclear whether trends in fatal and non-fatal self-harm continue to move in parallel over time. Understanding changes in the relationship between these indicators may provide important insights for mental health surveillance and service planning.

Methods: National self-harm hospitalisation data from the Australian Institute of Health and Welfare¹ and suicide mortality data from the Australian Bureau of Statistics⁴ were analysed for young people aged 15–24 years across Australia. Joinpoint regression was used to estimate annual percentage changes (APCs) in hospitalisation and mortality rates. The relationship between fatal and non-fatal self-harm outcomes was examined using hospitalisation-to-death ratios and comparative trend analyses.

Results: National trends demonstrated differing patterns between self-harm hospitalisation and suicide mortality. Among females, self-harm hospitalisation rates increased from 2013 to 2021 (APC 2.42%; CI: 0.49, 7.99) before declining substantially from 2021 to 2023 (APC -16.14%; CI: -24.95, -3.55). In contrast, suicide mortality among females increased over the study period (AAPC 1.76%; CI: 0.57, 2.94). Among males, both hospitalisation and mortality trends generally declined during the most recent period. These findings indicate that changes in hospital-treated self-harm were not consistently accompanied by corresponding changes in suicide mortality, particularly among young females. Hospitalisation-to-death ratios also declined over time, suggesting an increasing separation between fatal and non-fatal self-harm outcomes.

Conclusions and Implications: Declining self-harm hospitalisation rates do not necessarily indicate reductions in suicide risk among young people. The findings demonstrate that hospitalisation and mortality indicators may provide different perspectives on population mental health and should not be interpreted in isolation. Systems that rely on a single indicator may miss emerging suicide risk, emphasising the need for integrated monitoring approaches incorporating hospitalisation, mortality, and community service data. Particular attention may be warranted for young females, where trends in hospitalisation and mortality are diverging, warranting further investigation of potential service and system factors, including barriers to accessing care. Such approaches may improve identification of emerging risks, support targeted pathways and prevention strategies, and inform timely mental health service planning and decision-making.

Self-harm hospitalisation in females, Australia



Adolescent resilience and longitudinal mental health outcomes in peri-rural South Africa

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Introduction: Adolescents in Africa are the world's fastest growing population group. Despite escalating rates of mental health disorders, little is known regarding the role of protective mechanisms that characterise resilience in adolescent mental health globally and in Africa, where there is heightened exposure to adversities. Grit, typically defined as 'perseverance and passion for long-term goals' despite challenges, setbacks and adversity - can be considered as a psychological protective factor. To the best of our knowledge, no study to date has conducted a longitudinal analysis of the impact of grit as a resilience factor on adolescent mental health outcomes.

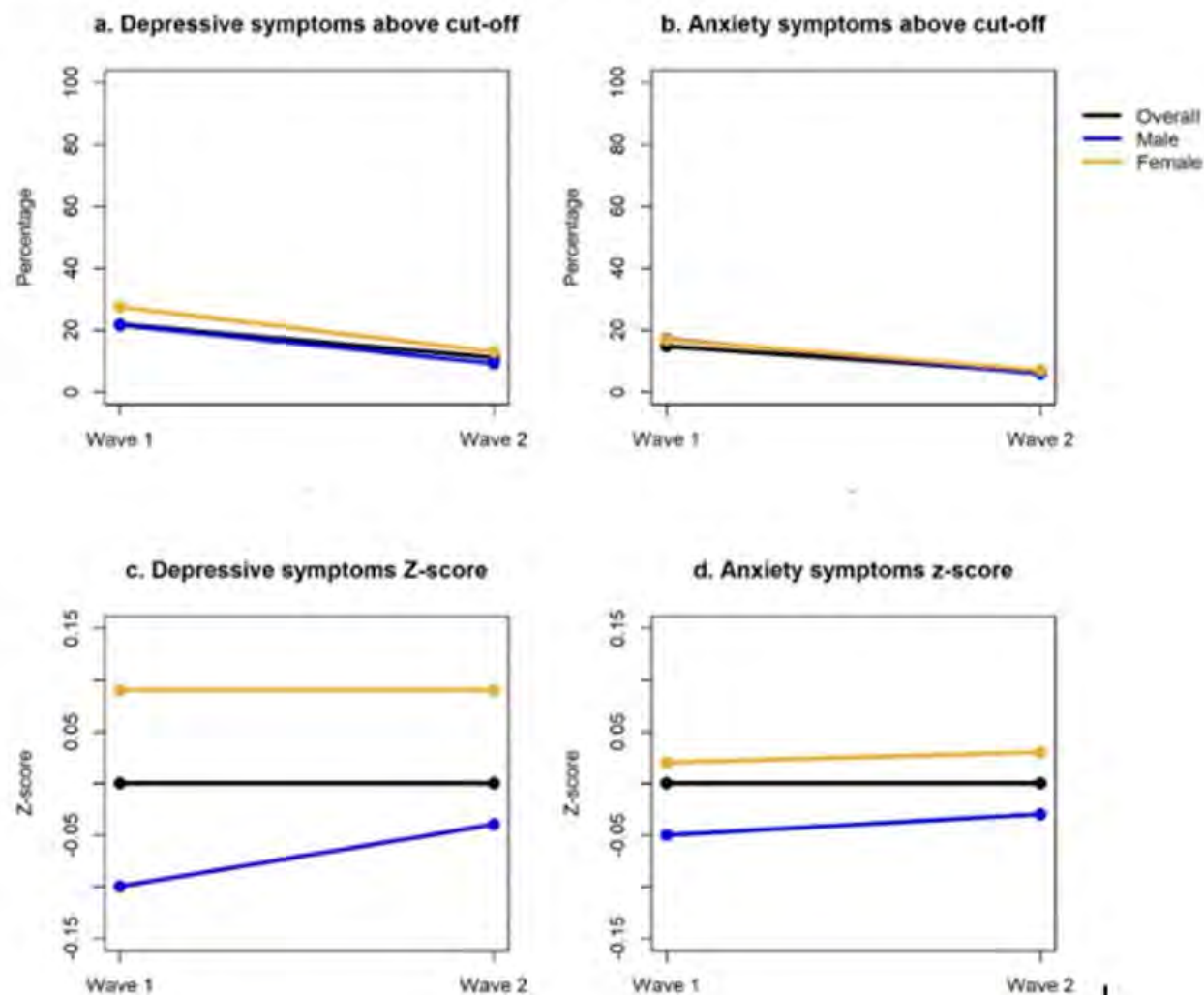
Methods: This study draws on two waves of the Asenze longitudinal population cohort. Internalising factors among adolescents (N = 1,174) from a peri-rural setting in KwaZulu Natal, South Africa, were tracked across two time points to investigate the relationship between grit - as a psychological resilience factor - and longitudinal mental health outcomes.

Results: Heightened mental health difficulty ratings for internalising factors were found across two study waves, with females reporting significantly higher rates of depression across both timepoints [$X^2(1, N = 1174) = 6.0, p = 0.015$ and $X^2(1, N = 1120) = 4.0, p = 0.046$ respectively]. Grit was found to be significant predictor of lower adolescent depression [$F(1, 1049) = 12.39, p < 0.001, R^2 = 0.01$] and anxiety severity [$F(1, 1049) = 11.54, p < 0.001, R^2 = 0.01$], but dependent on the severity of internalising symptoms, sociodemographic factors and exposure to socioeconomic adversity. In the most severe cases of adolescent depression and anxiety (top 20%), grit did not predict lower internalising symptoms.

Conclusions: Our study provides the first longitudinal evidence of the role of grit as a psychological resilience factor in adolescent mental health globally, and in Africa. Nevertheless, our results also highlight that in the most severe cases of mental health difficulties, psychological resilience factors such as grit may not be enough, and additional multifaceted interventions are needed. Potential differences in the mechanisms of adolescent resilience are highlighted that involve a dynamic interplay between bottom-up and top-down resilience factors in the African context.

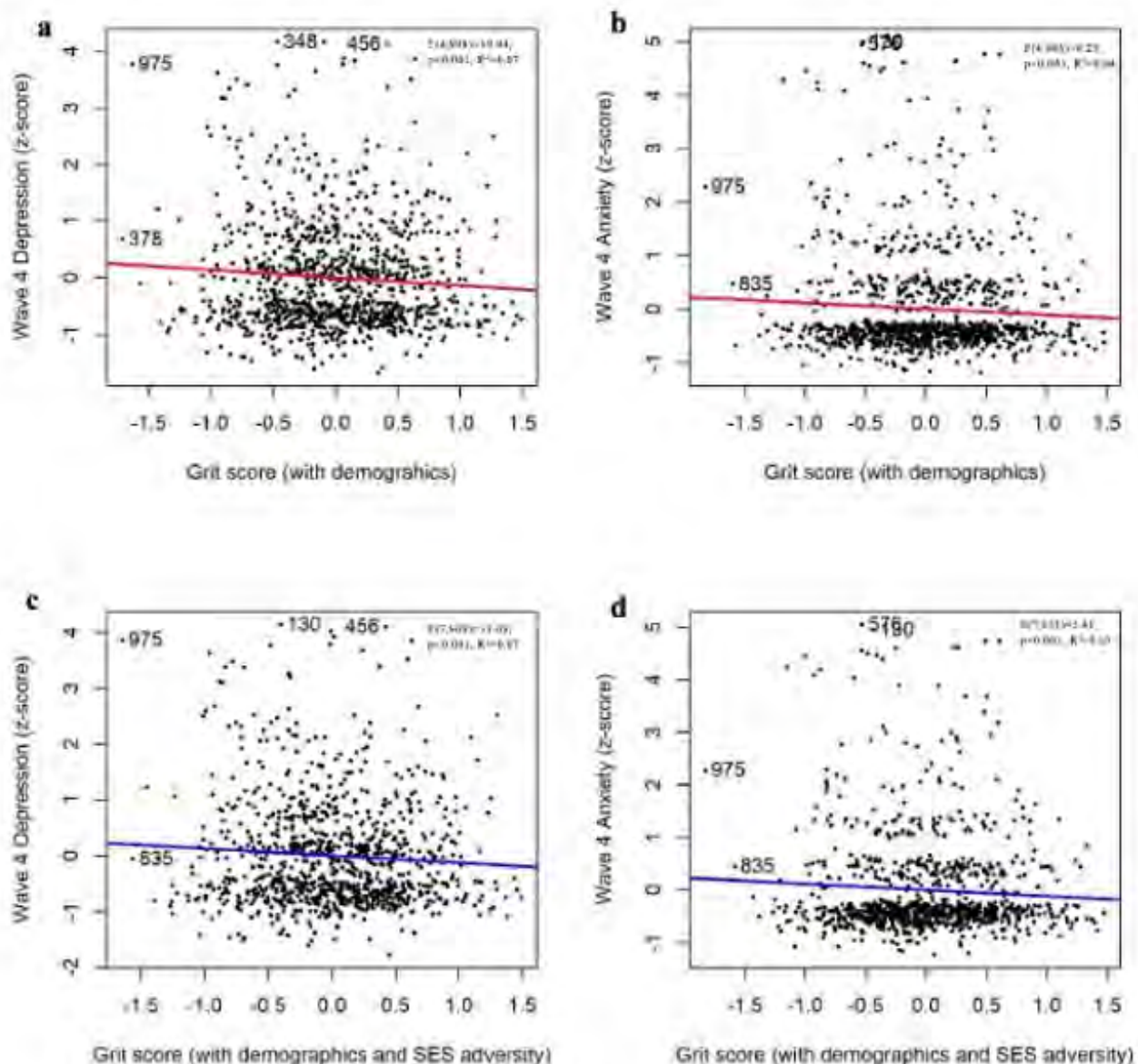
Depression and anxiety symptoms over two time points

Figure 1. Prevalence of depression and anxiety symptoms amongst adolescents over 2 time points. Depression and anxiety symptom presence and severity was examined by gender. 2a and 2b) Across all participants, 21.9% scored above the depression measure cut-off score and 13% scored above the anxiety measure cut-off scores at wave 3; this reduced to 11.1% and 6.4% respectively in wave 4. 2c) Depressive symptom z-scores across all participants at wave 3 and wave 4; females scored significantly higher at both time points, while males trended towards a higher symptom severity at wave 4. 2d) Anxiety symptom z-scores across all participants at wave 3 and wave 4; there were no differences gender differences in z-scores between wave 3 and wave 4.



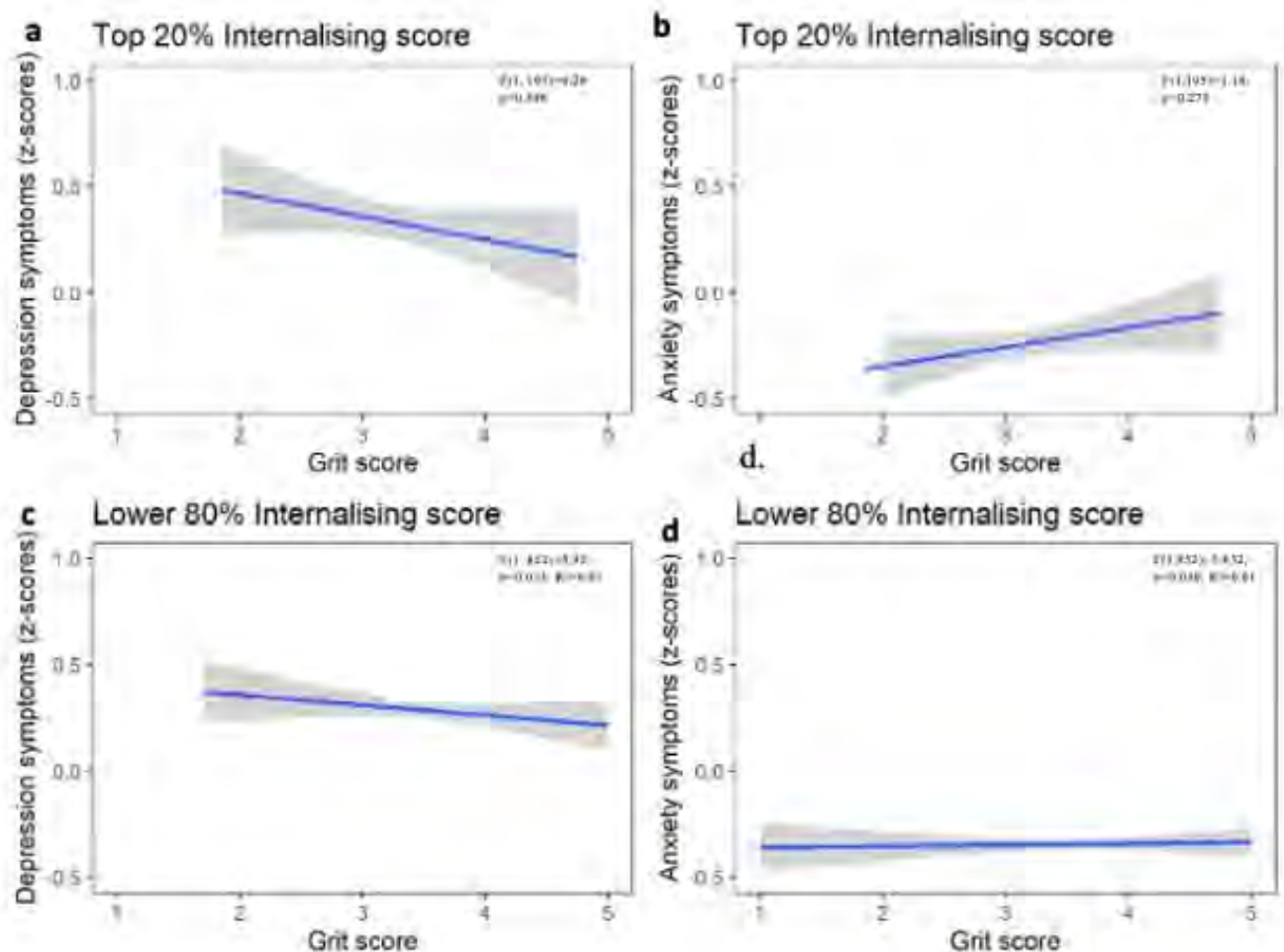
Grit and internalising symptom severity

Figure 2. Linear regression analyses to predict depressive and anxiety symptom severity based on grit. Grit scores were regressed onto continuous depressive symptoms z-scores (a) and anxiety symptom z-scores (b) at wave 4. Both models controlled for age, gender, and previous internalising symptoms at wave 3. Both models were significant, with higher grit contributing significantly to lower internalising symptom severity. When adding socioeconomic adversity (low asset index, food insecurity and low caregiver education) alongside the demographic variables (age, gender and previous internalising symptoms), the grit remained a significant predictor for depression (c) but not anxiety (d).



Grit across symptom severity

Figure 3. Differential predictive role of grit on internalising symptoms in adolescents across symptom severity. Grit was regressed onto the depressive and anxiety symptoms using z-scores for those presenting with the most severe cases of internalising scores (i.e., in the top 20%) at wave 3 and to the remaining 80%. Linear regression analyses showed that grit was a significant predictor of depressive (a) and anxiety (b) symptom severity in adolescents in the lower 80% range. However, grit was not a significant predictor for lower depressive (c) or anxiety (d) symptom severity in the most severe cases scoring in the top 20%.



Poster Session III

Friday, October 2nd, 2026

(PP 61 – PP 83)

A digital parenting intervention for Ukrainian caregivers

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Introduction: The prolonged war in Ukraine, which began in February 2022, has impacted the mental health and well-being of individual, families and communities. Parents play a key role in buffering the impact of war-related stressors on their children. While digital parenting interventions have shown to reduce children's emotional and behavioral problems in non-war settings, their feasibility and efficacy in war contexts remain largely unexplored. This study assessed feasibility and acceptability of a universal internet-based Let's Cope Together- Program for Ukrainian Caregivers of children aged 5–18 years. The second aim was to examine changes in parenting skills, parental and child distress and anxiety.

Method: We conducted a mixed-method study including pre-post surveys and interviews. Participants were recruited through parent-teacher chat groups. The intervention was an unguided internet-based parenting program based on Cognitive Behavioural Therapy elements, such as psychoeducation and skills training, and positive parenting. Parenting skills were assessed using Me as a Parent (MaaPs), parental mental health by Depression, Anxiety and Stress (DASS-21) and child's anxiety by parent-Screen for Child Anxiety Related Disorders (SCARED). Self-reported measures were collected at baseline and three weeks post-intervention. Semi structured interviews were conducted to explore mother's experiences using the intervention.

Results: Of 120 families contacted, 57 completed baseline assessments and 35 completed post-intervention questionnaire (38.6% dropout). Participants reported high acceptability of the intervention, and reported that the contents were easy, useful, relevant and learnt skills to manage their own and children's emotions. The most commonly used technique was breathing (82.9%), followed by relaxation and stabilization techniques (71.4% each). Significant improvements were observed in parenting skills (MaaPs total scores: $M = -6.69$; 95% CI $-10.21, -3.16$; $p < 0.001$), DASS-21 (total scores, $M = 25.14$; 95% CI $13.72, 36.47$), and parent-report SCARED total ($M = 13.24$; 95% CI $7.38, 19.09$) and sub-scores from baseline to post-intervention.

Conclusion: Internet based parenting programs may offer promising, scalable solutions to improve access to psychosocial support during war, when face-to-face services are often unavailable. Future studies should examine efficacy of digital parenting interventions with longer follow-ups in war-affected contexts.

Age of onset of alcohol and vape consumption in adolescents in Brazil: A multilevel survival analysis of cross-sectional data

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Introduction: The onset of drug use commonly varies by gender and socioeconomic status (SES). Over the last decade vape has become increasingly popular among adolescents. Considering that vaping might affect the use of other drugs during adolescence, we aimed to examine the age of onset for vape and alcohol, considering the competing events due to other drugs as cigarette, cannabis, inhalant and hallucinogens by gender and SES in the state of São Paulo, Brazil.

Method: Data came from a cross-sectional study in 13 schools, with 4,280 students from 7th grade (middle school) to 3rd grade (high school level). We examined the association with gender (female, male and others) and SES (six categories as defined by the Brazilian Association for Population Studies based on ownership of certain goods and services, having a domestic employee, and the head of household's educational level). The onset of risk of drug consumption was defined as the time of birth. Fine-Gray sub distribution hazards (SHR) models with cluster-robust standard errors for schools were fitted for each outcome. The analysis for SES was adjusted for race.

Results: There were 48.5% females (n = 2,075), and 1% identifying as others (n = 44). The median age of alcohol onset for females was 15 years, males 16 years, and for the higher SES it was 15 years, the middle classes 16 years and the lower classes 17 years. The proportions using vape, cigarettes, cannabis, inhalants or hallucinogens were insufficient to calculate median ages of onset. The SHR for alcohol use was 1.30 (95% CI: 1.16–1.45) and for vape use 0.93 (95% CI: 0.69–1.27) for females compared with males. The lowest SES class had the lowest SHR for alcohol use (0.71, 95% CI: 0.57–0.89) whereas the SRH for vape use was 1.26 (95% CI: 0.67–2.37) compared with the highest SES class.

Conclusion: Female students began drinking alcohol earlier than males. Low SES was associated with a lower likelihood of early onset of alcohol consumption. The data on vaping was inconclusive regarding differences in onset of consumption between genders and socio-economic classes.

Funding: Project funded by the Research Council of Norway

Altered core depressive symptoms in Post-COVID Fatigue: Evidence for an anhedonia-weighted phenotype

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Background: Post-COVID chronic fatigue syndromes are frequently associated with depressive symptoms and changes in motivation, energy, and reward processing. Although depressive symptoms are often evaluated using total severity scores, different symptom profiles may reflect underlying mechanisms. Anhedonia, defined as reduced interest or pleasure in activities, may be particularly relevant because of its relationship with reward system dysfunction and motivational impairment. This study investigated whether individuals with post-COVID-like chronic fatigue syndrome show a distinctive depressive symptom configuration.

Methods: A case-control design was used. Seventeen individuals with post-COVID-like chronic fatigue syndrome were compared with 34 matched pre-COVID community controls. Cases and controls were matched for sex, age, total PHQ-9 score, and proportions of participants scoring above PHQ-9 thresholds for at least mild and at least moderate depressive symptom severity. Depressive symptoms were assessed using the PHQ-9. Item-level scores were analyzed, and the depressed mood/anhedonia ratio was calculated at the individual level as PHQ-9 item 2, corresponding to the core depressive symptom feeling down, depressed, or hopeless, divided by PHQ-9 item 1, corresponding to anhedonia.

Results: The groups were similar in demographics, overall depressive symptom severity, and PHQ-9 severity thresholds. Despite this matching, depressed mood, assessed by PHQ-9 item 2, was significantly less pronounced in cases than in controls (0.58 ± 0.76 vs. 1.55 ± 0.88 ; $F=15.327$, $p<0.0001$). Conversely, anhedonia, assessed by PHQ-9 item 1, showed a non-significant tendency to be more prominent in cases (1.29 ± 0.82 vs. 1.11 ± 0.93 ; $F=0.458$, $p=0.502$). Accordingly, the depressed mood/anhedonia ratio was significantly lower in post-COVID fatigue cases than in controls (0.44 ± 0.92 vs. 1.39 ± 0.94 ; $F=10.352$, $p=0.002$), suggesting a relative shift from depressed mood toward anhedonia.

Conclusions: Depressive symptoms in post-COVID-like chronic fatigue syndrome may not simply represent conventional depression with comparable overall severity. Instead, they may show an anhedonia-weighted phenotype, characterized by motivational and reward-related impairment rather than prominent depressed mood. This altered symptom balance, despite comparable overall PHQ-9 severity, may have implications for diagnostic characterization, pathophysiological interpretation, and treatment strategies in post-COVID fatigue.

Keywords: Long COVID; Post-COVID fatigue; Anhedonia; Depressive symptoms; PHQ-9

Funding: Fondazione di Sardegna

Demographic and clinical characteristics

Table 1. Demographic and clinical characteristics of post-COVID-like fatigue syndrome cases and matched controls

Variable	Post-COVID-like Fatigue Syndrome n=17 (n, %)	Controls N=34 (n, %)	Matching status	Statistical test
Sex, females	15 (88.2%)	30 (88.2%)	Matched	Chi-square, df=1; $\chi^2=0$; p=1
Age, years	49.52 $\pm$ 11.91	49.08 $\pm$ 11.68	Matched	ANOVA, df=1,49; F=0.016; p=0.900
Total PHQ-9 score	10.23 $\pm$ 5.25	9.35 $\pm$ 4.52	Matched	ANOVA, df=1,49; F=0.303; p=0.585
PHQ-9 score >4, at least mild depressive symptom severity	15 (88.2%)	30 (88.2%)	Matched	Chi-square, df=1; $\chi^2=0$; p=1
PHQ-9 score >9, at least moderate depressive symptom severity	10 (58.8%)	20 (58.8%)	Matched	Chi-square, df=1; $\chi^2=0$; p=1
Note. Values are reported as n (%) or mean $\pm$ standard deviation. PHQ-9 = Patient Health Questionnaire-9. Groups were matched for sex, age, total PHQ-9 score, and PHQ-9 severity thresholds.				

PHQ-9 item-level symptom profile

Table 2. PHQ-9 item-level depressive symptom profile in post-COVID-like fatigue syndrome cases and matched controls

PHQ-9 item	Post-COVID-like Fatigue Syndrome (m, SD)	Controls (m, SD)	ANOVA, df=1,49	p
Item 1. Little interest or pleasure in doing things	1.29 ± 0.82	1.11 ± 0.93	F=0.458	p=0.502
Item 2. Feeling down, depressed, or hopeless	0.58 ± 0.76	1.55 ± 0.88	F=15.327	p<0.0001
Item 3. Trouble falling asleep, staying asleep, or sleeping too much	1.35 ± 0.76	1.47 ± 1.14	F=0.153	p=0.697
Item 4. Feeling tired or having little energy	2.00 ± 0.76	1.55 ± 0.88	F=3.232	p=0.078
Item 5. Poor appetite or overeating	1.11 ± 0.86	0.85 ± 1.06	F=0.768	p=0.385
Item 6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0.94 ± 0.99	0.91 ± 0.85	F=0.013	p=0.921
Item 7. Trouble concentrating on things, such as reading the newspaper or watching television	1.35 ± 0.90	0.94 ± 0.93	F=2.249	p=0.140
Item 8. Moving or speaking so slowly that other people could have noticed; or being so fidgety or restless that you have been moving around a lot more than usual	0.82 ± 0.70	0.85 ± 1.08	F=0.011	p=0.918
Item 9. Thoughts that you would be better off dead or of hurting yourself in some way	0.35 ± 0.47	0.20 ± 0.40	F=1.269	p=0.266
Note. Values are reported as mean ± standard deviation. PHQ-9 = Patient Health Questionnaire-9. Statistical comparisons were performed using one-way ANOVA.				

Depressed mood / anhedonia ratio

Table 3. Depressed mood/anhedonia ratio in post-COVID-like fatigue syndrome cases and matched controls

Derived index	Post-COVID-like Fatigue Syndrome (m, SD)	Controls	ANOVA, df=1,43	p
PHQ2/PHQ1 ratio: depressed mood/anhedonia	0.44 ± 0.92	1.39 ± 0.94	F=10.352	p=0.002

Note. Values are reported as mean ± standard deviation. The PHQ2/PHQ1 ratio was calculated at the individual level as the score for PHQ-9 item 2, “feeling down, depressed, or hopeless”, divided by the score for PHQ-9 item 1, “little interest or pleasure in doing things”. Statistical comparison was performed using one-way ANOVA with df=1,43. A lower ratio indicates a relative predominance of anhedonia over depressed mood. Participants with a PHQ-9 item 1 score of zero were excluded from ratio analyses because the index could not be computed. PHQ-9 = Patient Health Questionnaire-9.

Caring in crisis: A trauma-informed and systemic approach to mental health support for activists and professionals in a polarized world

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Introduction: In contexts of increasing social polarization, structural violence, and uncertainty, mental health outcomes are shaped by systemic determinants rather than individual vulnerability alone. Activists and professionals working with women survivors of sexual violence are particularly exposed to vicarious trauma, chronic stress, and burnout. The aim of this poster is to present an intervention designed to strengthen trauma-informed competencies among practitioners while promoting systemic and collective approaches to mental health that integrate both the care of survivors and the protection of caregivers' psychological well-being.

Method: This intervention is a structured, multi-session training workshop combining trauma-informed care principles with public health and psychosocial approaches. It is organized into cycles of collective learning and practice-based consolidation, supported and supervised by a multidisciplinary team including mental health professionals, a legal expert, and a forensic physician. It includes three core components: (1) acquisition of foundational knowledge on trauma, mental health, and the psychosocial needs of survivors; (2) development of practical skills in active listening, psychological assessment, and referral pathways; and (3) implementation of strategies for the prevention of vicarious trauma and the strengthening of resilience among practitioners.

Pedagogical methods include brief theoretical inputs, role-play exercises, structured peer and expert supervision, guided debriefing protocols, and self-regulation techniques such as grounding, breathing exercises, reflective journaling, and boundary-setting practices.

Results: An evaluation of the quality, acceptability, and relevance of the intervention was conducted among participants, showing strong engagement with the program and a positive perception of its clinical and organizational utility. A longitudinal follow-up is planned, with a six-month contact point to assess the sustainability of acquired competencies, the integration of practices into routine professional activities, and the evolution of strategies for stress management and vicarious trauma prevention.

Conclusion: In contexts of increasing polarization and high psychosocial burden, sustainable mental health responses require the integration of trauma-informed care within systemic public health approaches. Ensuring the protection of both survivors and frontline practitioners is essential to the development of ethical, effective, and resilient intervention systems.

Composite healthy lifestyle index and mental health outcomes among adults experiencing poverty in Québec

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Introduction: Healthy lifestyle behaviors are key determinants of health and contributors to the burden of non-communicable diseases and mental health conditions worldwide. Flourishing mental health reflects positive emotional, psychological, and social functioning. Evidence shows that modifiable lifestyle behaviors can support positive mental health and improve well-being, yet the influence of co-occurring behaviors remains poorly understood. This study examined the relationship between healthy lifestyle profiles, moderate or severe symptoms of depression (MSS-DEP), and flourishing mental health.

Method: The study includes a quota-based sample of 500 adults experiencing poverty in the province of Québec (Canada) who completed an online survey in 2025. MSS-DEP was defined by a PHQ-9 cutoff score of ≥ 10 , and mental health was categorized as languishing (low well-being/functioning), moderate (neither languishing nor flourishing), and flourishing (high well-being/functioning) based on the Mental Health Continuum. A composite healthy lifestyle index comprising six modifiable behaviors (physical activity, sedentary time, fruit/vegetable intake, sleep, alcohol, smoking) was created, with one point assigned for each healthy behavior (score range: 0–6). Scores were grouped into unfavourable (0–2), intermediate (3–4), and favourable (5–6) profiles. Multinomial regression analyses were conducted to examine associations between lifestyle categories and mental health, adjusting for socioeconomic factors and multimorbidity (i.e., 0–1 vs. 2 or more chronic physical conditions).

Results: Overall, 13.9% had a favourable lifestyle profile, 58.5% an intermediate profile, and 27.6% an unfavourable profile. Compared with the unfavourable lifestyle profile, adults in the intermediate and favourable groups had nearly twice the odds of flourishing mental health compared with languishing. Intermediate and favourable lifestyle profiles were further associated with decreased odds of MSS-DEP. Female sex, unemployment, and multimorbidity were associated with higher odds of MSS-DEP, while older age was associated with both lower odds of depression and higher odds of flourishing.

Conclusion: Among adults experiencing poverty, a healthier composite lifestyle profile was associated with higher odds of flourishing mental health and lower odds of depression symptoms. Although the cross-sectional design precludes causal inference, these findings support public health strategies in promoting multiple healthy lifestyle behaviors simultaneously as protective factors against symptoms of depression, as well as promoting positive mental health.

Funding: This research, conducted as part of the Concerted Actions program, was funded through a partnership between the Fonds de recherche du Québec – Société et culture, the Fonds de recherche du Québec – Santé, and the ministère de la Santé et des Services sociaux.

Examining pandemic-related stressors, incident PTSD, and anxiety-related functional impairment

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Introduction: Elevated rates of anxiety and posttraumatic stress disorder (PTSD) have been documented during the COVID-19 pandemic, but the role of specific stressors in the incidence of these disorders and in related functional impairment remains unclear. The aim of this study was to examine incident physician-diagnosed PTSD and anxiety disorder, as well as the presence of functional impairment due to symptoms of anxiety and associated factors (i.e., financial difficulties, frontline employment, COVID-19 infection, multimorbidity).

Methods: We analyzed data from 20,824 adults aged 35 years and over in the Canadian Partnership for Tomorrow's Health (CanPath), a large Canadian longitudinal cohort, who completed the 2020 and 2021 COVID-19 health surveys. The presence of incident PTSD and incident anxiety disorder was based on a self-reported physician diagnosis in 2021, but not in 2020. Among individuals reporting at least one problem on the GAD-7, difficulty performing daily activities due to symptoms was summarized as extremely or very difficult vs. somewhat difficult or not difficult at all. The main independent variables included stressors during the pandemic and were persistent financial difficulties (job loss/decrease in income), frontline employment (essential or healthcare work), COVID-19 infection, and multimorbidity (≥ 2 chronic physical conditions). Multivariable logistic regression models adjusted for age, gender identity, and race.

Results: The incidence of physician-diagnosed PTSD was 0.2%, while the incidence of physician-diagnosed anxiety disorder was also 0.2%. Additionally, 1.9% of participants reported functional impairment related to anxiety symptoms. Financial difficulties, frontline employment and multimorbidity were associated with higher odds of incident physician-diagnosed PTSD. Higher odds of anxiety-related functional impairment were observed among individuals reporting financial difficulties, COVID-19 infection, and multimorbidity. No significant associations were found between pandemic-related stressors and incident physician-diagnosed anxiety disorder.

Conclusion: Financial difficulties, frontline work during the pandemic, and health status were associated with incident physician-diagnosed PTSD and with anxiety-related functional impairment. From a public health perspective, these findings reinforce the need for mental health surveillance and implementation of supports among these groups to mitigate the impacts of the pandemic context.

Funding: This work was supported by the Canadian Institutes of Health Research (CIHR)[RFN: MS3 173106].

Contextual bias in suicide risk assessment among school gatekeepers: The role of diagnostic priming and cognitive closure

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Introduction: Suicide risk assessment might be susceptible to cognitive biases, as evaluators may rely on heuristic processing rather than clinical indicators alone. This is particularly relevant in preliminary screening by gatekeepers and professionals with limited diagnostic expertise. The present study examined whether diagnostic context influences perceived suicide risk and whether this effect differs between individuals with low versus high need for cognitive closure (marker of cognitive rigidity).

Methods: Eighty-six high-school teachers evaluated a standardized vignette describing a high school student presenting clinically significant, though moderate suicide risk. Participants were randomly assigned to one of two conditions: (a) a diagnostic noise condition, introducing irrelevant assessment content, or (b) a suicide-risk availability priming condition increasing accessibility of suicide-related categories. Case standardization was based on jury ratings, SAD PERSONS framework and the Tool for Assessment of Suicide Risk (TASR). Participants rated suicide risks from 1 (none) to 10 (high). They additionally completed the Attitudes Toward Suicide Scale (ATTS-R), the Suicide Literacy Scale (SLS), and the Short Need for Closure Scale (NFCS). To examine whether the effect of diagnostic context differed by cognitive rigidity, participants were subdivided into low- and high groups on need for cognitive closure subscales.

Results: Participants in the priming condition assigned significantly higher suicide risk ratings ($M = 7.73$) than those in the noise condition ($M = 6.74$), $p = .046$, $d = .44$. Among participants high in overall need for closure, priming substantially elevated perceived risk ($M = 8.26$) relative to noise ($M = 5.85$), $p < .001$, $d = 1.28$, whereas no significant difference emerged among those low in need for closure, $p = .475$. Similar patterns were observed for high need for predictability ($p < .001$, $d = 1.46$), and high tolerance of ambiguity ($p = .008$, $d = .92$). Suicide literacy was not significantly associated with risk evaluations.

Conclusion: Suicide risk assessment is shaped not only by clinical information, but also by diagnostic context and the evaluator's cognitive characteristics. These findings highlight the importance of integrating awareness of contextual biases into suicide prevention training.

Cumulative trauma in Lebanon: What a community sample reveals about the limits of event-based models

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Introduction: Given the growing global disruption and displacement, investigating cumulative trauma pathways and how they shape mental health across the lifespan is increasingly relevant today. Lebanon, subject to decades of war, displacement, economic collapse, and political turmoil, provides a prime geopsychological context to examine cumulative trauma, its predictors, and associations with distress, post-traumatic growth (PTG), and religious coping. This study aims to inform trauma frameworks in chronic adversity settings, where discrete, time-bound models have been critiqued for their applicability.

Method: A cross-sectional online survey was administered to 216 Lebanese adults (84.7% female; 66.2% aged 18–34). Cumulative trauma was assessed using the Cumulative Trauma Scale–Short Form (yielding trauma events and trauma impact) and the Cumulative Trauma Disorder Scale (CTDS; trauma-specific distress) following their validation within a Lebanese population. Measures also included the PTSD Checklist, Post-traumatic Growth Inventory, depression and anxiety scales, and positive and negative religious coping subscales. Spearman correlations examined bivariate associations. A generalised linear model (Gamma, log link) was used to evaluate multivariable predictors of cumulative trauma events, adjusting for sociodemographic, childhood adversity, displacement, food insecurity, geographic, and social support indicators.

Result: Trauma events strongly correlated with trauma impact ($p=.72$) and PTSD symptoms ($p=.39$). Cumulative traumatic distress (CTDS) was strongly correlated with PTSD symptoms ($p=.69$), suggesting overlapping but distinct symptom profiles. PTG scores were relatively high ($M = 62.3$) alongside moderate distress, suggesting co-occurring growth and distress. Positive religious coping predicted PTG ($p=.36$), but not depression; negative religious coping predicted depression ($p=.36$) but not PTG. Multivariable analyses showed dose-response associations between displacement frequency and cumulative trauma ($p < .001$). Childhood sexual abuse, food insecurity, and higher education predicted greater exposure. Geographic location and religious background also showed adjusted associations, with patterns warranting finer-grained geographic and community-level investigation.

Conclusion: Trauma exposure in this sample clustered along lines of structural vulnerability rather than discrete events, and growth emerged alongside ongoing distress under conditions of continuing adversity, without the post-trauma stability existing growth frameworks generally assume. These findings suggest that trauma research in chronically affected contexts may require frameworks built from within these settings rather than adapted into them.

Embodied community healing networks in Southeast Oceania, Australasia, and beyond

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Introduction: This abstract reports on field-based work through University of Philippines auspiced by the regional office of UNICEF, focusing on the Southeast Asia Oceania Australasia region. The work entailed extended travel across the region to identify and learn from locally embedded community members—described here as natural nurturers—who provide psychosocial support during periods of man-made and natural disaster. These individuals are frequently Indigenous or members of small minority communities and operate outside formal institutional mental health systems.

Method: An intercultural qualitative, connoisseur based field approach was used, involving direct engagement with community healers, paraprofessionals, and informal support networks across multiple countries. Emphasis was placed on identifying naturally occurring healing practices, modes of knowledge transmission, and networking structures. Particular attention was given to the role of embodied, or somatic, practices and to the use of mobile phone-based communication systems that enabled local adaptation and horizontal knowledge sharing across regions.

Results: 136 Natural Nurturers and 15 Natural Nurturer networks were located. Despite cultural and geographic diversity, these Natural Nurturers demonstrated convergent healing practices centred on somatic, body-based approaches, including movement, rhythm, breathing, posture, touch, intercultural healing artistry and relational presence. Mobile phones were widely used to coordinate responses, adapt practices to local conditions, and transmit knowledge without centralised control. A focused case example from illustrated downstream impact—Community-based Somatic Healing Ways from SE Asian inter-clan conflict contexts were passed to a Western Kenya colleague who adapted them for 24 local paraprofessional women. These women subsequently supported approximately 2,100 at-risk children affected by local clan conflict, contributing to restoring emotional regulation, social functioning, and community stability.

Conclusion: The findings indicate that scalable, effective psychosocial healing systems already exist within communities themselves. Locally grounded, somatic, and relational approaches—when recognised, supported, and networked rather than replaced by alien ways can form adaptive, resilient systems of care. These community-based networks, offer important implications for global mental health, disaster response, and psychiatric practice, particularly in contexts where formal services are limited or culturally mismatched.

Historical trauma and the legacies of slavery in Martinique: A decolonial and transgenerational analysis in times of global disruption

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Introduction: Mental health in Afro-descendant populations affected by historical oppression, slavery, colonialism and ongoing socio-economic marginalization cannot be fully understood without considering local representations and expressions of trauma. Standard diagnostic frameworks often overlook these dimensions, limiting relevance for culturally diverse communities. This study explores subjective experiences of trauma, its intergenerational transmission, and coping strategies, highlighting implications for mental health understanding and public health practice, particularly in contexts of disruption and vulnerability.

Method: In 2025, a qualitative exploratory study was conducted in Martinique using in-depth interviews with Afro-descendant participants. Narratives focused on personal trauma experiences, perceived intergenerational transmission, and strategies for coping and resilience. Thematic analysis incorporated historical, social, and cultural determinants, including legacies of colonialism, systemic racism, and socio-economic disadvantage, situating mental health outcomes across the lifecourse.

Results: Findings reveal the accumulation of multiple, often unrecognized forms of violence, spanning interpersonal, structural, and historical traumas. Standardized diagnostic tools frequently fail to capture the impact of racism and historical legacies. Trauma expression manifested as diminished self-worth, anger, identity fragility, social isolation, discrimination, and social disengagement. Transmission occurred through family violence, silences, educational practices, and culturally or spiritually mediated channels rooted in collective history. Coping and resilience strategies were contextually situated, mobilizing individual, community, and symbolic resources. These insights provide guidance for public health efforts in prevention and community-based support for trauma-affected populations.

Conclusion: Our findings underscore the importance of integrating historical, cultural, and contextual perspectives into mental health practice. Understanding trauma through these lenses is essential for developing locally and intergenerationally relevant interventions, improving community-level mental health support, and enhancing preventive approaches in public health. This approach aligns with global public health priorities by addressing root causes of mental health problems across the lifecourse and promoting culturally sensitive, inclusive, and effective care.

Is fatigue associated with mental health? A Pre- vs Post-COVID cross-sectional survey comparison

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Background: Fatigue is a frequently reported symptom among both adolescents and adults and is recognized as one of the enduring manifestations of long COVID-19. The examined the prevalence and associated factors of self-reported fatigue among Finnish adolescents before the COVID-19 pandemic (2018) and after the pandemic (2023).

Methods: Two cross-sectional surveys utilizing similar methodological procedures were conducted among adolescents in two medium sized cities (Rovaniemi and Salo) in Finland in 2018 and 2023. Fatigue severity was assessed using the Checklist Individual Strength (CIS) questionnaire. The analytical sample comprised 5,583 adolescents aged 13–17 years ($n = 2,774$ in 2018; $n = 2,809$ in 2023). Linear regression analyses were conducted to evaluate associations between total fatigue scores, survey year, mental health and explanatory variables.

Results: The prevalence of severe fatigue increased among girls, from 16.2% in 2018 to 24.3% in 2023 ($p < 0.001$), while no significant change was observed among boys (6.7% vs. 5.6%, $p = 0.239$). Congruently, mean fatigue scores among girls rose from 29.1 to 32.2 ($p < 0.001$), while the increase among boys (24.6 to 25.2) was not statistically significant ($p = 0.081$). The fatigue score was higher among females by 0.7 points in 2023 ($\beta = 0.68$; 95% CI 0.07, 1.28), but not statistically significant among males ($\beta = 0.03$; 95% CI -0.56, 0.62). Higher levels of internalizing problems were associated with elevated fatigue scores (females: $\beta = 5.00$, 95% CI 4.68, 5.32; males: $\beta = 3.74$, 95% CI 3.37, 4.11). Similarly, externalizing problems were associated with higher fatigue scores (females: $\beta = 2.87$, 95% CI 2.53, 3.20; males: $\beta = 2.19$, 95% CI 1.85, 2.53).

Conclusion: The post-pandemic increase in fatigue among girls highlights the importance of continued focus on adolescent mental and physical health, particularly in relation to internalizing and externalizing problems.

Mental health burden and perspectives among recently resettled Afghan adults in California, USA: A mixed methods study

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Introduction: Conflict exposure and migration are associated with high psychiatric morbidity among Afghan adults. The mass displacement of Afghan citizens following the Taliban's return to power in August 2021 exposed critical limitations in refugee mental health infrastructure in host countries, including the United States. Understanding the mental health experiences and perspectives within Afghan refugee communities is critical to providing post-migration support.

Methods: Partnering with the Public Health Institute's Center for Immigrant and Refugee Health, we aimed to determine the proportion of common mental health disorders (Composite International Diagnostic Interview Version 3.0; PTSD Checklist for DSM-5), lifetime trauma exposure (Life Events Checklist for DSM-5), and substance use (Alcohol, Smoking and Substance Involvement Screening Test) in a sample of Afghan adults in California, USA. Free-listing, in-depth interviews (IDI), and focus group discussions (FGD) with community members, community leaders, resettlement agency staff, and healthcare providers contextualized survey results. Free-listing data were analyzed using Smith's composite salience; IDI and FGD transcripts underwent inductive thematic analysis.

Results: Of the 100 survey respondents, few met criteria for mental health disorders (any psychiatric disorder: <5%; psychotic experiences: 7.6%) or substance use (tobacco: 10%) despite high exposure to potentially traumatic events (lifetime exposure to any type of event: 89%). In comparison, qualitative results revealed that this population experienced a high burden of mental health conditions, where worrying was listed as the most salient mental health problem (Smith's composite salience = 0.670). IDI and FGD analyses highlighted barriers to symptom disclosure related to culturally rooted stigma and deprioritization of mental health in the context of social and legal pressures.

Discussion: The observed discordance between quantitative and qualitative results suggests that stigma and structural vulnerabilities (i.e., legal and social standing) increase barriers to disclosure. Addressing these gaps requires community-informed care models and expanded mental health infrastructure within Afghan resettlement communities in the US, including decoupling mental health support from structural factors and educating individuals on the symptoms of mental health disorders. Further, distribution of governmental and international resources is often determined by quantitative metrics; thus, improving disclosure among resettled communities is critical for adequate resource allocation.

Mental health in indigenous children and adolescents: The contribution of cultural background

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Background: The purpose of this study is to describe and compare the prevalence of mental health problems in Aymara and non-Aymara children and adolescents. In Chile, the Aymara community has a population of approximately 52,000 people who are concentrated mainly in the highlands area and the cities in the North of the country. Among the most distinctive cultural characteristics of this population is the intergenerational communication, where older adults' advice and counsel younger persons. In addition, the family functioning is characterized by cooperation and complementarity in the performance of the various tasks, including the participation of the children and adolescents.

Methods: The study sample comprised 1839 students from 8 to 19 years, from educational institutions of Northern Chile. Forty-nine percent of students identified with the Aymara ethnic group. The Child and Adolescent Evaluation System was used to evaluate internal and external problems. Initially, to characterize the sample, the mean, standard deviation, minimum and maximum, skewness, kurtosis and the Shapiro-Wilk normality test were obtained for each continuous variable used in this study. Comparisons were performed based on the means of the scores of continuous mental health variables according to the ethnicity of the participants using independent samples t-test. To evaluate the effect size, the coefficient proposed by Cohen was estimated. Although the variables in this sample are not normally distributed, parametric comparative analyses were used, because the t-statistic is sufficiently robust under conditions of skewness and with large sample sizes ($n > 50$).

Results: In Elementary school, Aymara students showed significantly lower scores in externalized problems and in high school, there were significantly lower scores in interiorized, exteriorized and other problems than Non-Aymara students.

Conclusion: It seems that the legacy of the Aymara culture has favored the development of protective factors in relation to the mental health of these students.

People treated in emergency rooms for mental disorders in Peru: Analysis of real-world data 2018-2025

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Introduction: Emergency services are often points of access for people experiencing mental health crises. Estimating the number of people treated is key to planning resources and assessing external impacts, such as the COVID-19 pandemic. This study aimed to describe the monthly number of patients treated for mental disorders in emergency services in Peru between 2018 and 2025, according to patients' sociodemographic characteristics and the characteristics of the healthcare facilities where care was provided.

Methods: Morbidity analysis in emergency services using records from the National Superintendency of Health. The ICD-10 codes included ranged from F00 to F99.9. The number of patients treated monthly was determined by sex, age, sector, category, and department. The average monthly number of patients treated during the study period was calculated, and crude and age-standardized rates were estimated using the projected Peruvian population and the World Health Organization standard population, respectively.

Results: In Peru, between 2018 and 2025, the average monthly number of people treated for mental disorders in emergency departments was 9,040, representing 1.04% of the average monthly number of patients treated for any ICD-10 diagnosis. The monthly treatment rate (per 100,000 population) ranged from 25.3 in 2020 to 29.5 in 2023. The most frequently treated groups, by sex and age group, were women (60%) and older adults (12%), respectively. The most common diagnosis throughout the study period was Unspecified anxiety disorder (ICD-10 code F41.9), accounting for 26.8% of all cases. Emergency visits managed at the primary care level represented 6% of the total.

Conclusion: During the study period, there was little variation in the monthly treatment rate for mental disorders in emergency departments across health facilities in Peru. However, most patients were treated in hospitals and specialized institutes. Further research is needed to identify the factors associated with the use of emergency services at different levels of care in order to strengthen care processes and improve the service capacity of health facilities.

Prior psychopathological conditions and risk of subsequent stressful life events: Longitudinal evidence from the World Mental Health International College Student Initiative

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Introduction: Stress generation theory proposes that psychopathology is itself a cause of subsequent stress, not merely a consequence. We tested this prospectively by examining whether lifetime DSM-5 psychopathological conditions predict Year 2 stressful life events (SLEs) and chronic stressors in a large international college student cohort.

Methods: The study included N = 11,549 first-year university students from 13 countries, followed up one year later. Lifetime DSM-5 mental disorders and self-destructive behaviors were assessed at baseline. Year 2 SLEs (11 types) and chronic stressors (7 types) were self-reported at follow-up and further classified as dependent or independent of prior behavior. Adjusted risk ratios were estimated with survey-weighted multivariate hierarchical quasi-Poisson regression (log link), clustering observations within universities and stratifying by country. For each prior condition, we summarized results across models as the percentage of positive risk ratios, percentage statistically significant, and geometric mean of significant positive risk ratios.

Results: Risk ratios were positive across 80-100% of SLE models and 100% of chronic stressor models for all psychopathological conditions. Among statistically significant positive associations, geometric mean RRs ranged 1.21 – 1.74 for SLEs and 1.34 – 1.82 for chronic stressors. PTSD and suicidal ideation showed the strongest chronic stressor effects (RRSig+ = 1.82 each); alcohol and drug use disorders showed the strongest for SLEs (RR = 1.74 and 1.72).

Conclusion: Lifetime psychopathology broadly and consistently predicted subsequent stress exposure, supporting stress generation theory across diagnostic categories. Effects were stronger and more consistent for chronic stressors and acute life events.

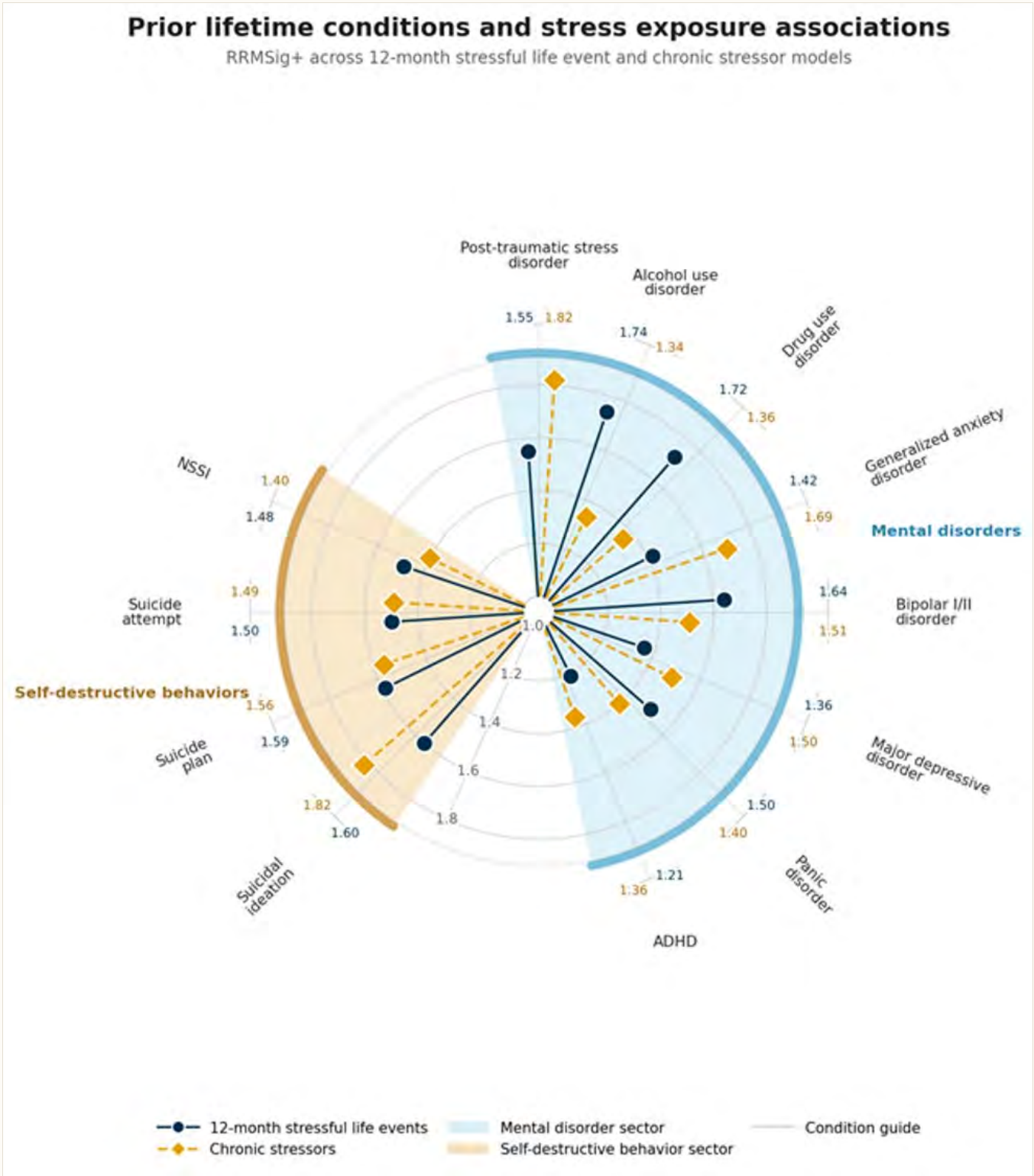
Prior lifetime conditions and stress exposure

Table 1*Associations of Prior Lifetime Conditions With 12-Month Stressful Life Events and Chronic Stressors*

Prior lifetime condition	12-month SLEs (10 models)			Chronic stressors (7 models)		
	%RR+	%RRSig+	RRMSig+	%RR+	%RRSig+	RRMSig+
Mental disorders						
Major depressive disorder	100	70	1.36	100	100	1.50
Bipolar I/II disorder	100	50	1.64	100	71.4	1.51
Generalized anxiety disorder	100	90	1.42	100	100	1.69
Panic disorder	100	50	1.50	100	100	1.40
Post-traumatic stress disorder	100	90	1.55	100	100	1.82
Drug use disorder	80	60	1.72	100	42.9	1.36
Alcohol use disorder	90	70	1.74	100	42.9	1.34
ADHD	100	10	1.21	100	71.4	1.36
Self-destructive behaviors						
Nonsuicidal self-injury (NSSI)	100	80	1.48	100	100	1.40
Suicidal ideation	100	70	1.60	100	100	1.82
Suicide plan	100	70	1.59	100	100	1.56
Suicide attempt	100	60	1.50	100	100	1.49

Note. Abbreviations: SLEs, stressful life events; %, percentage; SE, standard error of %; %RR+, percentage of risk ratios > 1.0 from multivariable models of recent stressors (11 stressful life event models; 7 chronic stress models); %RRSig+, percentage of risk ratios > 1.0 and statistically significant at the 0.05 level (two-sided, design-based tests) from multivariable models of recent stressors (11 stressful life event models; 7 chronic stress models); RRMSig+, the geometric mean of RRSig+ estimates; ADHD, attention-deficit/hyperactivity disorder; NSSI, non-suicidal self-injury.

Associations across stress models



Psychological distress, depression, suicidal ideation, and wellbeing among individuals accessing the WHO Self-Help Plus intervention in South Sudan: Findings from the M(h)IND project

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Introduction: Scalable psychological interventions such as the World Health Organization's Self-Help Plus (SH+) have demonstrated effectiveness in randomized controlled trials, yet evidence on their large-scale implementation in humanitarian settings remains limited. As part of a broader implementation study evaluating the scale-up of SH+ in crisis-affected South Sudan, this study aims to characterize the sociodemographic, contextual, and clinical profile of individuals accessing SH+ and to examine factors associated with mental health distress, depression, suicidality, and wellbeing.

Methods: We analyzed cross-sectional baseline data from a hybrid type-1 implementation study conducted in 25 SH+ centers across six counties in South Sudan between April 2023 and July 2025. Adults accessing the freely available SH+ intervention were invited to participate and, after providing informed consent, completed assessments of psychological distress (Kessler-6 [K-6]), depressive symptoms (PHQ-9), suicidal ideation (PHQ-9), and subjective wellbeing (WHO-5). Multivariable linear and logistic regression models were used to examine associations between mental health outcomes and sociodemographic and contextual characteristics.

Results: Of the 11,546 individuals screened, 9,588 were included in the analysis. Participants were predominantly female and had a mean age in the mid-thirties. A substantial proportion reported food deprivation in the previous month and limited access to water sources. High rates of severe psychological distress, severe depressive symptoms, poor wellbeing, and suicidal ideation were observed across the sample. In multivariable analyses, both individual-level and structural factors were independently associated with poorer mental health outcomes.

Conclusions: Individuals accessing scalable psychological interventions in South Sudan experience a substantial burden of distress, depression, and suicidal ideation, which appears to be shaped by both individual and structural determinants. By characterising the populations that engage with scalable psychological interventions, these findings can inform the delivery, adaptation, and scale-up of evidence-based, task-shifted mental health care in humanitarian settings.

Translation and cultural adaptation of the secondary traumatic stress media-induced questionnaire (STSM-IQ) for the Italian population

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Introduction: In the context of global disruption, individuals are increasingly exposed to traumatic events through the media. Secondary Traumatic Stress, traditionally studied among helping professionals, is now increasingly recognized as relevant to the general population through media exposure, and the Secondary Traumatic Stress Media-Induced Questionnaire (STSM-IQ) was developed to assess this response. This study aims to translate, culturally adapt, and validate the STSM-IQ for use in the Italian context.

Methods: Translation and cultural adaptation followed international guidelines, including forward translation, back-translation, and expert review by eight specialists using an 80% clarity agreement threshold. Statistical validation was conducted on a sample of 344 university students consisting of 184 females (53.5%) and 160 males (46.5%). Because cross-loadings were theoretically expected, dimensionality was examined using ESEM with WLSMV estimation and Geomin rotation. Internal consistency reliability was assessed using Cronbach's alpha and McDonald's omega and preliminary convergent validity through Spearman correlations with traumatic online content exposure.

Results: Face validity procedures showed strong agreement among experts, supporting the semantic and conceptual adequacy of the Italian translation. After comparing multiple alternative factor structures, the two-factor ESEM solution emerged as the best-fitting and most theoretically interpretable model: $\chi^2(89)=121.515$, CFI=.997, TLI=.996, RMSEA=.033, 90% CI [.016, .046], SRMR=.048 (Table 1). The two dimensions were interpreted as Intrusion/Traumatic Involvement and Hyperarousal/Avoidance, with a moderate inter-factor correlation, $r=.571$. Internal consistency was satisfactory for both subscales ($\alpha=.82$, $\omega=.86$ for Intrusion/Traumatic Involvement; $\alpha=.84$, $\omega=.89$ for Hyperarousal/Avoidance). The total scale also showed good reliability, $\alpha=.88$, $\omega=.89$ (Table 2). Spearman correlations showed small-to-modest and statistically significant preliminary convergent validity between STSM-IQ scores and exposure to traumatic online content, with correlations ranging from $p=.116$ to $p=.244$.

Conclusion: Overall, these findings support the Italian adaptation of the STSM-IQ as a reliable and valid instrument that can be used both through a total and through two subscales. The next step will be to complete further psychometric validation in a clinical sample to assess the instrument's reliability, sensitivity, and ability to discriminate clinically relevant levels of distress to strengthen the use of the STSM-IQ for epidemiological research, prevention strategies, and clinical assessment of indirect trauma in the digital age.

Model fit of the two-factor ESEM solution

Table 1. Model Fit of the Two-Factor ESEM Solution for the STSMI-Q – Italian version

Model	χ^2	df	CFI	TLI	RMSEA	90% CI RMSEA	SRMR
ESEM 2 factors	121.515	89	.997	.996	.033	.016–.046	.048

Note. χ^2 = chi-square test statistic; df = degrees of freedom; CFI = Comparative Fit Index; TLI = Tucker–Lewis Index; RMSEA = Root Mean Square Error of Approximation; 90% CI RMSEA = 90% Confidence Interval for the RMSEA; SRMR = Standardized Root Mean Square Residual.

ESEM factor loading and reliability

Table 2. ESEM Factor Loading and Reliability of the STSMI-Q – Italian version

Item	F1	F2
F1: Intrusion / Traumatic Involvement		
it2: Dopo essere stata esposto/a ai contenuti traumatici attraverso i media, il mio cuore ha iniziato a battere forte.	.683	-.008
it3: Dopo essere stata esposto/a ai contenuti traumatici attraverso i media, mi è sembrato di rivivere il trauma vissuto da quelle persone.	.559	.009
it5: Mi sono sentito/a scoraggiato/a riguardo al futuro.	.395	.276
it6: I ricordi dei contenuti traumatici a cui sono stata esposto/a attraverso i media mi hanno turbato/a.	.831	-.065
it10: Ho pensato ai contenuti traumatici a cui sono stato/a esposto/a attraverso i media anche quando non avevo intenzione di farlo.	.591	.167
it12: Ho evitato persone, luoghi o cose che mi ricordavano i contenuti traumatici a cui sono stato/a esposto/a attraverso i media.	.433	.349
it13: Ho fatto sogni inquietanti sui contenuti traumatici a cui sono stato/a esposto/a attraverso i media.	.538	.174
it14: Ho voluto evitare di espormi ad altri contenuti traumatici sui media.	.480	-.008
it16: Ho avuto la sensazione che potesse accadere qualcosa di brutto.	.526	.216
F2: Hyperarousal / Avoidance		
it1: Dopo essere stata esposto/a ai contenuti traumatici attraverso i media, mi sono sentito/a emotivamente insensibile.	-.206	.328
it4: Ho avuto difficoltà a dormire.	.378	.463
it7: Ho avuto scarso interesse a stare in compagnia di altre persone.	-.034	.756
it8: Mi sono sentito/a nervoso/a.	.040	.828
it11: Ho avuto difficoltà a concentrarmi.	.048	.790
it15: Sono stato/a facilmente irritabile.	.036	.753
Cronbach's α	.82	.84
ω total	.86	.89
ECV	.53	.73
Number of items	9	7

Note. Values shown in bold indicate primary factor membership. Cronbach's α = reliability coefficient; ω = McDonald's reliability coefficient; ECV = Explained Common Variance.

Understanding parental hesitancy toward paediatric COVID-19 vaccination in Europe: A systematic review

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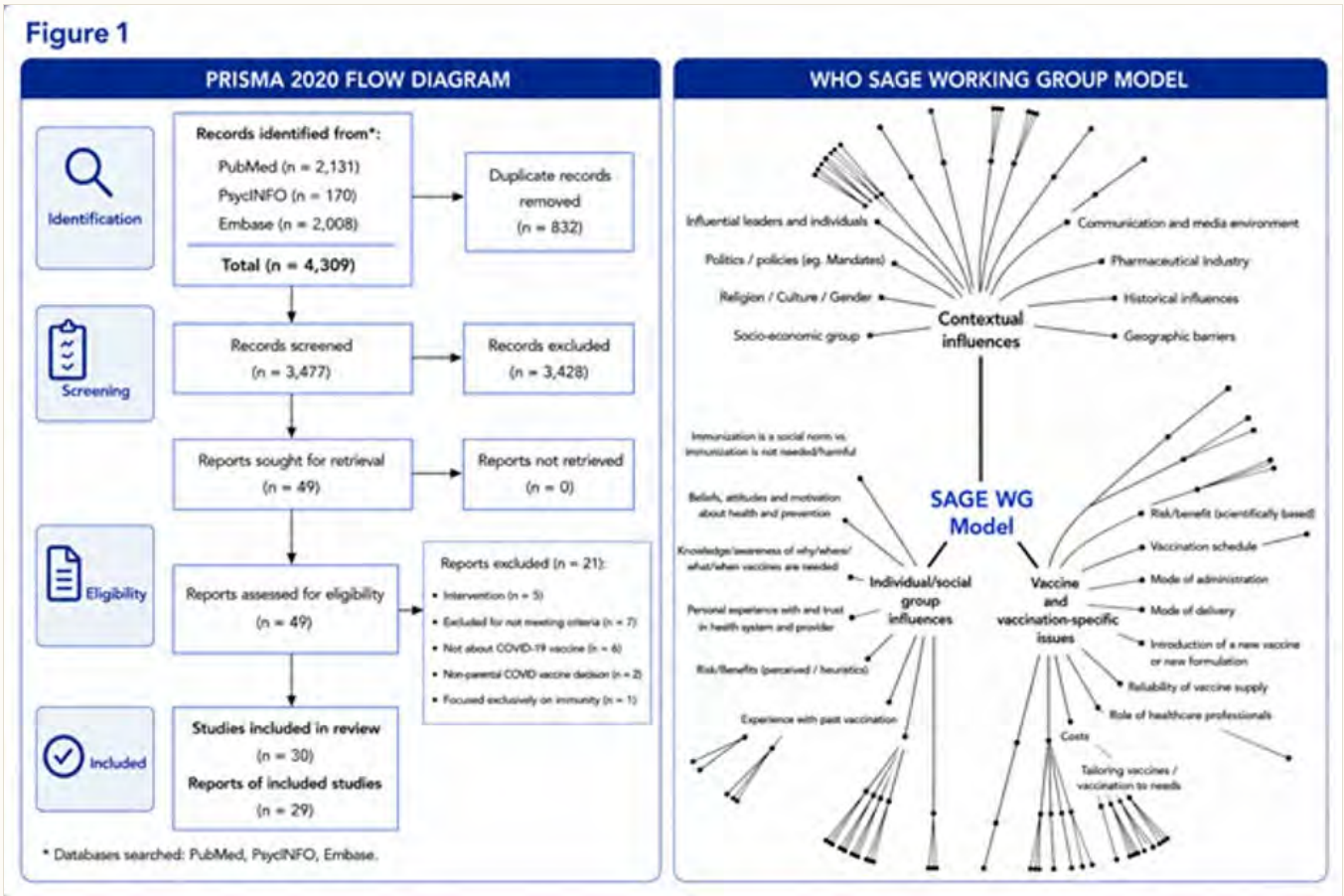
Background: During the COVID-19 pandemic, parental uncertainty about vaccinating children became an important public health concern. However, evidence on determinants of paediatric COVID-19 vaccine hesitancy in Europe remains fragmented. This systematic review synthesised factors associated with parental hesitancy and acceptance in the European context.

Methods: The review followed PRISMA 2020 and was registered in PROSPERO (CRD42024549284). PubMed/MEDLINE, PsycINFO, and Embase were searched for studies published from January 2020 to April 2024. Eligible studies were quantitative observational investigations conducted in EU countries and focused on parents' or guardians' attitudes, intentions, or behaviours regarding paediatric COVID-19 vaccination. Given heterogeneity across settings, measures, and analytical approaches, findings were summarised narratively using the WHO SAGE framework. Study quality was assessed with the NIH Quality Assessment Tool.

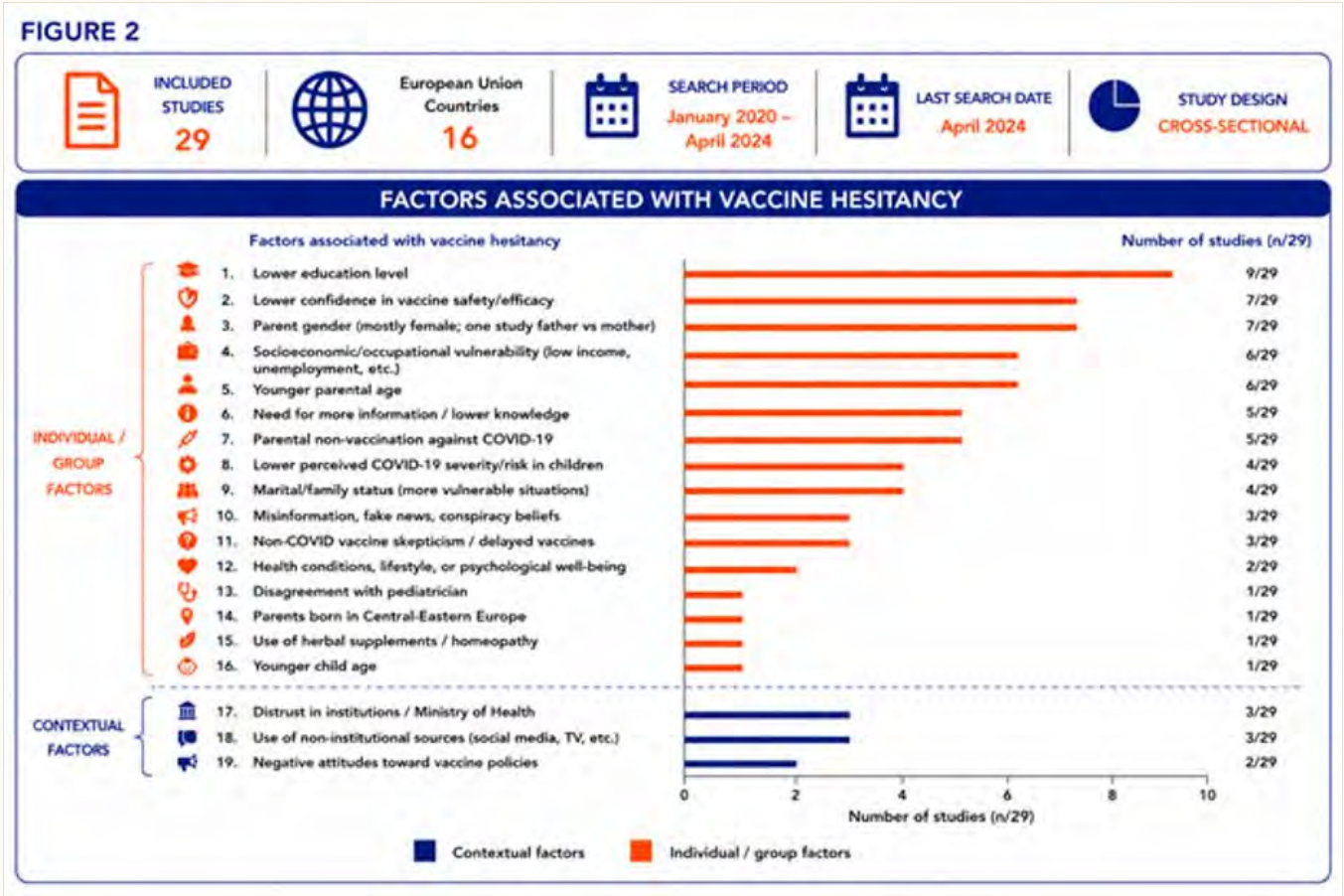
Results: Twenty-nine studies were included, comprising 78,073 participants. Parental hesitancy was more often associated with lower education and income, younger parental and child age, lower institutional trust, reliance on non-official information sources, lower perceived COVID-19 risk or severity, and reduced confidence in vaccine safety and effectiveness. Acceptance was more often associated with higher education, older parental and child age, previous vaccination behaviour, institutional trust, paediatricians or physicians as key information sources, and favourable attitudes toward vaccination and public health measures. A behavioural continuity pattern emerged, with prior vaccination adherence linked to acceptance and non-vaccination or incomplete vaccination linked to hesitancy. Hesitancy also clustered with low threat appraisal, lower knowledge, safety and efficacy concerns, misinformation-related fear or stress, policy disagreement, and weaker alignment with pro-vaccination norms. Conversely, paediatrician or physician recommendation and healthcare contact appeared to support acceptance. Vaccine- and rollout-specific factors, including recommendation stability, access pathways, communication coherence, and delivery arrangements, were comparatively underexamined.

Conclusions: Parental hesitancy toward paediatric COVID-19 vaccination in Europe appears multidimensional, shaped by socioeconomic position, trust, information environments, perceived risk, and healthcare relationships. Strengthening parental vaccine confidence will likely require tailored, trust-based, and context-sensitive strategies combining clear institutional communication with active involvement of paediatricians and other trusted healthcare professionals. Future research should explicitly assess vaccine- and delivery-specific determinants, an underexplored interface between vaccination policies, health-system organisation, and parental decision-making.

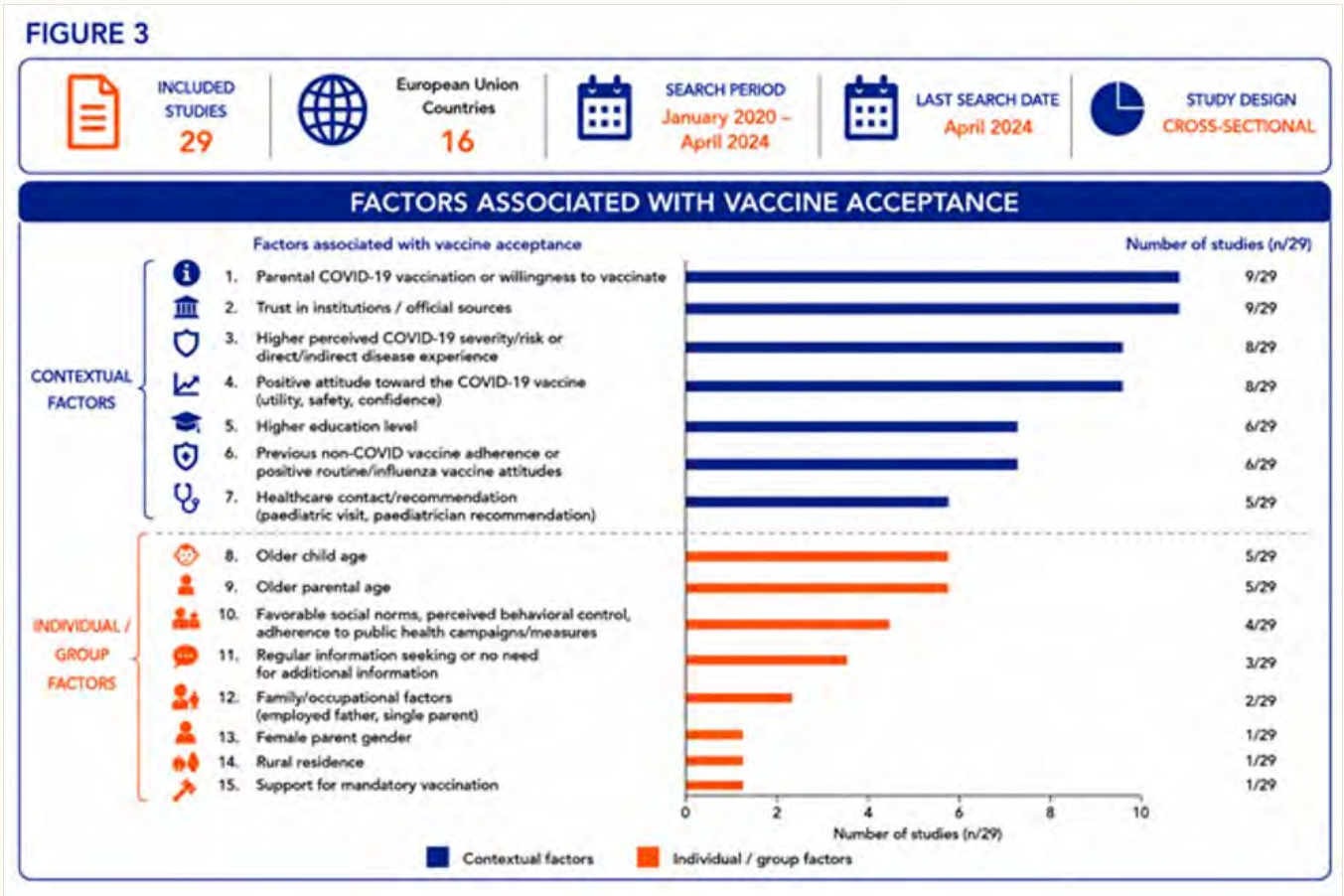
PRISMA flow and WHO SAGE model



Factors associated with vaccine hesitancy



Factors associated with vaccine acceptance



What does funding disruption actually cost? Estimating the economic cost of treatment attrition in Kenya's methadone maintenance treatment programme: A case of Mathari medically assisted treatment clinic

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Introduction: Methadone Maintenance Treatment (MMT) is a life-saving intervention for Opioid Use Disorder. Kenya's MMT programme, initiated in 2014, comprises 9 clinics across 7 high-burden counties, provided by the Government of Kenya but implemented through a mixed funding model heavily reliant on donor support. The 2025 USAID/CDC directive halting HIV prevention funding raised critical sustainability concerns. This analysis estimated the economic drug related harm per patient dropping out of Mathari MMT Clinic during the funding disruption of January 2025–January 2026.

Methodology: A retrospective secondary cost analysis was conducted using nationally reported data (January 2025–January 2026) and doctoral research data. Provider infectious disease costs were derived from routine MOH-731b facility reports submitted to KHIS (HIV, hepatitis C, TB, STI, PEP). This was multiplied by unit costs per national harm-reduction guidelines for people who use and inject drugs. Patient-borne costs were modelled from doctoral data and applied to the attrition cohort. This was CPI-adjusted to 2026 prices and time-weighted by months out of treatment.

Results: Active patients declined from 367 to 307 (–16.3%) over 13 months. A total of 88 attritions occurred (9.37% attrition rate), 42 (47.7%) of which were as a result of negative outcomes (5 deaths, one being an overdose, 2 involuntary discontinuations, 35 losses to follow-up (20 HIV-related)). The estimated 1-year cost of these 37 attritions was Kes 29.2 million (~USD 224,752; Kes 789,668/patient). Estimated patient costs included drug expenditure (59.0%) and productivity loss (9.9%). Estimated provider costs (30.6%) were dominated by infectious disease: hepatitis C, (54% of provider costs), HIV management (27.9%), totalling 81.8% of provider costs. Incarceration accounted for 9% of estimated provider costs.

Conclusion: This analysis provides modelling to demonstrate the potential impact of MMT funding disruption in sub-Saharan Africa. Findings project that funding disruption has the potential to disrupt treatment thus increasing infectious disease comorbidity, return to active drug use and criminal justice engagement. As the funding landscape for HIV prevention programmes shifts, cost-effective treatment integration and ring-fenced MMT financing are essential to guide the transition toward sustainable, government-led financing models that preserve equitable access to MMT.

A cross-sectional study of health services of Chinese adults with mental disorders

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Introduction: Using data from the China Mental Health Survey, this study aimed to describe health service utilization and its associated factors among Chinese adults with mental disorders, to inform policy and prevention strategies.

Methods: China Mental Health Survey is a nationally representative survey enrolled 32,552 community residents aged ≥ 18 years from 31 provinces. Mental disorders were diagnosed according to DSM-IV criteria using face to face interviews with the Composite International Diagnostic Interview (CIDI-3.0), the Structured Clinical Interview for DSM-IV (SCID), and the 10/66 dementia diagnostic package. Descriptive epidemiological methods were used to calculate the prevalence of health services utilization among community adults with mental disorders. A non conditional logistic regression model was applied to examine risk factors of health services utilization for community adults who had mental disorders during the past 12 months.

Results: Health services utilization of adults with mental disorders in China: The weighted rate of consulting was 15.29%, the weighted rate of treatment was 13.55%, and the proportion of consulting at psychiatric or psychological departments was 39.80% among adults with any disorder (excluding dementia). The proportions of consulting at mental health workers, other medical workers, and other professionals were 33.79%, 48.10%, and 18.87%, respectively. The proportion of utilizing medication or psychotherapy was 35.92%. The weighted rate of treatment during the past 12 months among adults with mental disorders was 3.08%. A large proportion of adults with mental disorders delayed their treatments for 10 years or more. Factors associated with treatment during the past 12 months among adults with mental disorders: Multivariate non conditional logistic regression showed that rural residents and unwillingness to seek help were risk factors for treatment among adults with mood disorders, and being employed was a risk factor for treatment among adults with anxiety disorders.

Conclusions: The status of health service utilization among community residents with mental disorders in China shows a low utilization rate, long treatment delays, and inappropriate health seeking behaviors. To improve unmet needs, it is essential to enhance mental health education, raise awareness of mental disorders, and increase investments in mental health services.

Affect regulation in ADHD, bipolar disorder and BPD: Findings from the DynAMoND study

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Background: Attention-deficit/hyperactivity disorder (ADHD) is a common neuro-developmental disorder that often persists into adulthood. Moreover, it is frequently accompanied by bipolar disorder (BD) as well as borderline personality disorder (BPD). It is unclear whether these disorders share underlying pathomechanisms, given that all three are characterized by alterations in affective states, either long or short-term. BD is characterized by infrequent but intense mood shifts, while ADHD and BPD involve more dynamic emotional fluctuations. It is yet to be determined whether these disorders represent distinct phenomena or different points on a spectrum of affective dysregulation. This study seeks to distinguish the emotional dysregulation of BPD, ADHD, and BD by using digital phenotyping, a measurement burst electronic-diary method with different sampling rates, and accelerometry to measure participants' activity. The DynAffect framework conceptualizes emotional dynamics via homebase (baseline affect), variability (fluctuation), and attractor strength (return to baseline). The DynAMoND study investigates affective and self-esteem dynamics across these disorders, examining whether patterns differ by diagnosis and how daily stressors and sleep relate to emotional changes.

Methods: The study included 363 participants from five European centers (Italy, Spain, Switzerland, Norway, Germany): 94 BPD, 62 BD, 129 ADHD, and 78 healthy controls. Baseline assessments measured diagnostic symptoms, early trauma, impulsivity, and sleep. Participants completed five smartphone-based ecological momentary assessment bursts over a year (five consecutive days each, ten daily prompts) capturing mood (valence, tense arousal, energetic arousal), self-esteem, daily events, sleep, and experiences. Accelerometers recorded activity. Affective dynamics were modeled using an Ornstein-Uhlenbeck Jump Process, estimating homebase, variability, and attractor strength while accounting for stress reactivity.

Results: Preliminary analyses show diagnostic differences in affect regulation. BPD and BD exhibit higher affective variability. BPD also shows heightened reactivity to positive events and lower, more variable self-esteem homebase. ADHD demonstrates increased reactivity to negative events, while healthy controls show the strongest self-esteem attractor strength.

Conclusions: Findings highlight distinct yet partially overlapping patterns of emotional regulation across BPD, BD, and ADHD. Ongoing analyses will examine interactions with sleep, contextual factors, and passive mobile sensing to further characterize daily emotional processes.

Transitions – Digital mental health literacy program used among the first-year medical students: A cross-cultural study in Argentina, Finland and Lithuania

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Background: Rates of mental health problems are rising among university students, increasing the need for effective support. Strengthening mental health literacy offers a scalable way to improve early recognition and help seeking. This study examined changes in medical students' MHL and emotional symptoms before and after digital Transitions MHL program in different countries.

Methods: Transitions, including two online lectures and digital resource, was delivered to the first-year medical and dentistry students in Argentina, Finland and Lithuania. The students completed e-questionnaires assessing their MHL and mental health outcomes before and after Transitions and two months after baseline.

Results: Mental health knowledge ($p < .001$) improved in all countries, but the significant cross-country differences at baseline persisted until two months after baseline. Help-seeking attitudes improved in all countries ($p < .001$) and stigma decreased in Lithuania ($p < .001$). Changes in emotional problems varied across countries. Argentinean students reported reduced DASS depression ($p < .001$), while Finnish students experienced fewer symptoms in DASS anxiety ($p = 0.05$) and increased DASS depression ($p = 0.05$). DASS total score ($p < .001$), DASS anxiety ($p < .001$) and stress (DASS stress: $p < .001$; perceived stress scale: $p < .001$) decreased among Lithuanian students.

Conclusion: Digital Transitions MHL program can be a recommendable approach to improve medical students' MHL in different countries, especially mental health knowledge and help-seeking attitudes. However, cultural context may shape the positive influence of the program on reduction of stigma.

A psychometric evaluation of the Parent-Report Affective Reactivity Index (ARI-P) in a real-world implementation sample of 4-year-old children

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Introduction: Early irritability has been linked to externalizing and internalizing problems in later childhood and adolescence, while also being increasingly recognized as a transdiagnostic feature of a wide range of mental disorders. The parent-report Affective Reactivity Index (ARI-P) is widely used for screening irritability, but evidence of its psychometric evaluation in real-world practice with preschool-aged children in Nordic settings remains limited. We evaluated the factor structure, reliability, validity, and candidate cutoffs of the ARI-P in a Finnish sample of 4-year-olds.

Methods: Data came from the implementation study of the Finnish Strongest Families Parenting intervention, conducted during 2015-2026 in Finnish routine child health clinics. Parents of 57,767 children attending 4-year health check-ups completed the ARI-P and the Strengths and Difficulties Questionnaire (SDQ). Confirmatory factor analysis tested the one-factor structure, with fit assessed by CFI, TLI, RMSEA, and SRMR. Internal consistency was estimated with Cronbach alpha, while inter-item associations were tested with polychoric correlations. Validity was examined through associations with the ARI-P impairment item and the five SDQ subscales. ROC analyses were conducted using SDQ item 26 as a proxy for disruptive behaviors.

Results: The mean ARI-P total score was 2.16 (SD=2.54). Confirmatory factor analysis supported a one-factor structure, with excellent model fit (CFI=0.999, TLI=0.998, RMSEA=0.044, SRMR=0.057) and factor loadings from 0.62 to 0.97 (Table 1). Internal consistency was good (Cronbach alpha=0.81). ARI-P scores increased with parent-rated impairment: 1.47 (SD=1.66) for no impairment, 6.13 (SD=2.12) for some impairment, and 10.0 (SD=1.90) for certain impairment (ANOVA $p<.001$). ROC analysis showed acceptable discrimination (AUC=0.7788, 95% CI 0.775-0.783). The Youden cutoff of 2 balanced sensitivity (0.7032) and specificity (0.7443), whereas 80th and 90th percentiles of ARI-P total score increased positive predictive value (0.8968 and 0.9689) but reduced sensitivity (Table 2). SDQ subscale validity analyses will be updated in August.

Conclusion: The ARI-P offers a practical way to detect preschool irritability in child health care. Its brief format and interpretable cutoffs may support earlier assessment and better targeting of preventive parenting interventions.

ARI-P factor analysis and ROC cutoffs

Table 1. Factor analysis of ARI-P items

Item	Mean (SD)	Missing	Factor loading
Easily annoyed by others	0.50 (0.61)	408 (0.7%)	0.73
Often loses temper	0.55 (0.66)	349 (0.6%)	0.97
Stays angry for a long time	0.10 (0.33)	195 (0.3%)	0.62
Angry most of the time	0.02 (0.14)	177 (0.3%)	0.81
Gets angry frequently	0.29 (0.54)	326 (0.6%)	0.86
Loses temper easily	0.57 (0.65)	339 (0.6%)	0.94
CFI			0.999
TLI			0.998
RMSEA			0.044
SRMR			0.057

Table 2. ROC cutoff performance using SDQ item 26 as proxy indicator

Method	Cutoff	Sensitivity	Specificity	PPV	NPV	Accuracy
80th percentile of ARI-P total score	4	0.3834	0.9511	0.8968	0.5823	0.6529
90th percentile of ARI-P total score	6	0.1914	0.9932	0.9689	0.5261	0.5721
Optimal Youden J	2	0.7032	0.7443	0.7527	0.6939	0.7227

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21st Congress of the WPA Epidemiology and Public Health Section

Cagliari, Sardinia, Italy · September 29 – October 2, 2026

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