World Child & Adolescent Psychiatry

ISSUE 29, January 2026

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

World Psychiatric Association
Child and Adolescent Psychiatry Section's
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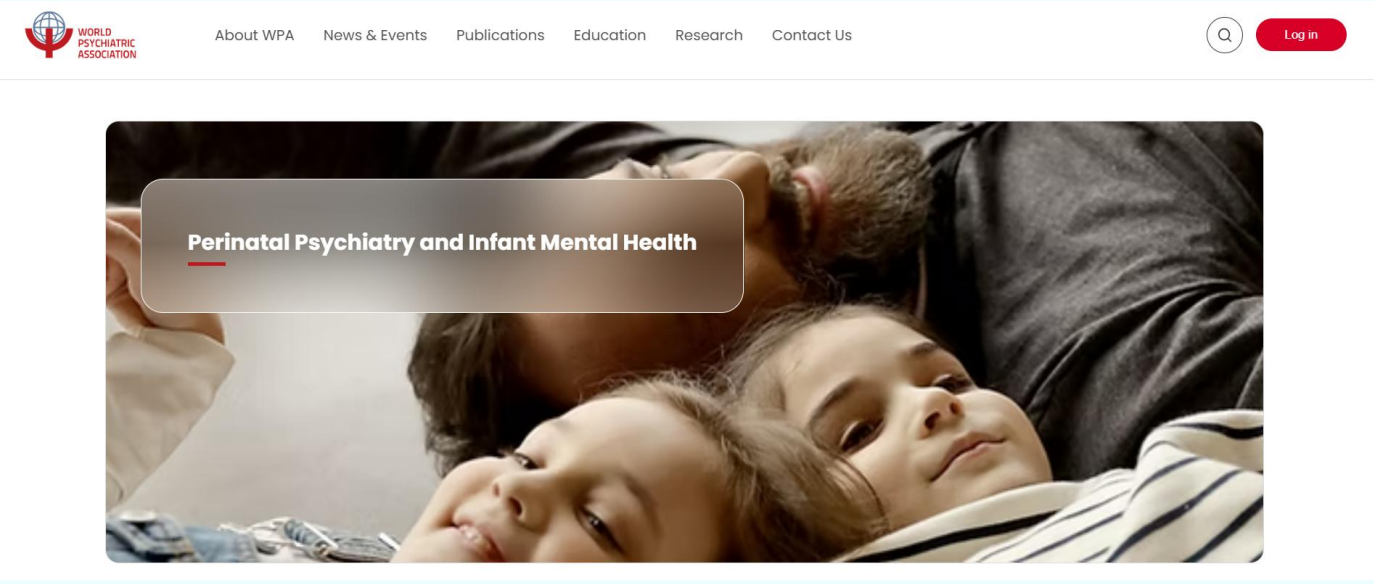

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Chair's column

Prof. Anthony Guerrero (Hawai'i)

Chair, Child and Adolescent Psychiatry Section, World Psychiatric Association

Happy, peaceful, and prosperous New Year to everyone!

This edition of World Child and Adolescent Psychiatry (World CAP), the official newsletter and e-journal of the World Psychiatric Association's Child and Adolescent Psychiatry Section, represents a synergistic effort between our Section and the WPA Section on Perinatal Psychiatry and Infant Mental Health.

We, Dr. Anthony Guerrero and Dr. Miri Keren, as the two chairs of the respective sections, are pleased to welcome you to this special issue. We come together with an urgent message: that all members of our sections must collectively stand up for the rights of infants, children, and adolescents, as they face multiple and unprecedented adversities, including armed conflict, that endanger their lives and/or their development. We must therefore strive to learn as much as we can about what is going on around the world, so that we may be optimally prepared to assume advocacy and leadership roles on behalf of the youth and families that we serve.

Keren, Abdallah, and Tyano (2019)[1], speaking with a unified voice on behalf of the World Association for Infant Mental Health (WAIMH), summarized: "The needs and rights of all children are the same everywhere: nutritious food, adequate healthcare, a decent education, shelter, and a secure and loving family… but are totally disregarded by the very definition

[1] Keren M, Abdallah G, Tyano S. WAIMH position paper: Infants' rights in wartime. Infant Ment Health J. 2019 Nov;40(6):763-767. doi: 10.1002/imhj.21813. Epub 2019 Aug 15. PMID: 31415108.

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of war." Guerrero (2024), in a message primarily to psychiatric educators, proposed that "we have the unique ability to give the world a glimpse into the perspectives of children and others who may not have a legal voice but whose voices we have a strong moral imperative to follow, in consideration of our society's future."[2]

We introduce this issue with the hope that all will benefit by learning about issues facing youth throughout the world and by developing an awareness of international colleagues who could become potential partners in creating a mentally healthier world for youth, present and future. In finding themes and projects that can involve our two sections, we increase the numbers of linkages that can transcend traditional boundaries and unite diverse groups around our common interest in the mental health of infants, children, and adolescents.

This issue highlights multiple principles and approaches to working with youth of all ages and building optimal systems of care. Dr. Keren describes the factors contributing to continuity and discontinuity in child psychopathology from infancy to childhood. Drs. Vlatka Boričević Maršanić and Emilija Maršanić discuss the Croatian experience in integrating Family Dynamics into Child Psychiatry. These two papers educate us on the essential interplay between parent, family, and infant/child throughout development, and the importance of integrating these perspectives into treatment in a global context. Fitting with the theme of expertise spanning the perinatal period, infancy, childhood, and adolescence, Dr. Jorge Srabstein (originally from Argentina, currently in the United States), via an interview, discusses his career as a pediatrician and neonatologist, as a psychiatrist and child and adolescent psychiatrist, and as an academic and expert in bullying and maltreatment.

Also in this issue, Drs. Anthony James (from New Zealand) and Edward Miller (from the United Kingdom) discuss a psychodynamically and systems-informed approach to leadership in our specialty, specifically in inpatient units. Dr. Farshid Tehrani discusses connecting CAP trainees across borders, particularly through the European Federation of Psychiatric Trainees (EFPT). Drs. Leonida Ngongi and Gemma Simbee bring the status of CAP training in Tanzania. Finally, Dr. Carolina Herrera-Ortiz, from Mexico, summarizes the experience of the 25th World Congress of Psychiatry in

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[2] Guerrero, A.P.S. The Psychiatrist at the Theater: "Peace on Your Wings," a Review and a Reflection. Acad Psychiatry 48, 195–196 (2024). https://doi.org/10.1007/s40596-023-01929-9

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Prague and inspires us all to look forward to the forthcoming 26th World Congress of Psychiatry in Stockholm, where more collaborations will hopefully be possible.

World CAP serves as an important venue for "improving child and adolescent mental health by connecting global wisdom with everyday practice and advocacy," and the editorial team continues to invite you to submit articles on topics that can stimulate further dialogue and knowledge advancement.

We hope that 2026 will be a year of creative partnerships and friendships, towards a more just and peaceful world.

Peace and Happy Readings!

Prof. Anthony Guerrero, Chair, WPA Child and Adolescent Psychiatry Section

Prof. Miri Keren, Chair, WPA Perinatal Psychiatry and Infant Mental Health Section

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Editor's column

Flávio Dias Silva, MD, MSc (Brazil)

Tomoya Hirota, MD, (USA/Japan)

Dear colleagues,

This issue of World Child & Adolescent Psychiatry brings together diverse voices from across the globe, reflecting the journal's mission to bridge scientific knowledge, clinical practice, training, and advocacy in child and adolescent mental health.

In the 'Clinical Practice News' section, Dr. Miri Keren offers a comprehensive and clinically grounded exploration of continuity and discontinuity in child psychopathology from infancy to childhood. Drawing on attachment theory, family functioning, and longitudinal research, the article highlights how early symptoms are not destiny, while underscoring the critical role of parental mental health, family stress, and sustained intervention in shaping developmental trajectories.

The section 'Child and Adolescent Mental Health around the World' brings four papers. The first is an in- depth article by Drs. Vlatka Boričević Maršanić and Emilija Maršanić on integrating family dynamics into child psychiatry, illustrated through the Croatian experience; the authors demonstrate how systemic and family-focused approaches enhance assessment accuracy and treatment effectiveness, while also discussing structural challenges such as workforce shortages. On the other hand, from Tanzania, Africa, Dr Leonida Ngongi and Dr Gemma Simbee tell a little about the progresses and the challenges of the specialty in a country with more than 60 million people. A third contribution comes from an Oceania and Europe partnership - Drs. Edward Miller and Anthony James address service-level complexity in Intentional action in CAMHS inpatient leadership; integrating psychodynamic theory, AMBIT principles, and mindful leadership, this article proposes a reflective, values-driven framework for sustaining therapeutic cultures in high-pressure inpatient settings. Finally, Dr Farshid Monshizadeh Tehrani highlights the work of the European Federation of

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Psychiatric Trainees in this section, emphasizing international collaboration, trainee networks, and new transnational projects aimed at strengthening cohesion and shared standards within child and adolescent psychiatry.

The 'Educational Opportunities' section presents an interview with Dr. Jorge Srabstein centered on his *book Bullying, Impact on Health, and Beyond*. Through his professional journey and reflections, the interview broadens the concept of bullying to a wider spectrum of maltreatment, emphasizing prevention, detection, and intervention across schools, families, workplaces, and communities.

Finally, the Meeting Report from Dr. Carolina Herrera-Ortiz summarizes key themes from the 25th World Congress of Psychiatry in Prague, highlighting major advances and global perspectives in child and adolescent mental health, as well as the central role of early intervention and international knowledge exchange.

Together, the contributions in this issue reflect a shared understanding: improving child and adolescent mental health requires attention to development, families, systems, leadership, and global collaboration. We hope this issue informs practice, inspires dialogue, and encourages readers to engage actively with the worldwide child and adolescent psychiatry community.

Happy readings!

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Invitation to submit

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

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

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

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

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

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

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

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

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

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Clinical Practice News

Factors Contributing to Continuity and Discontinuity in Child Psychopathology from Infancy to Childhood.

Miri Keren, MD, from Israel.*

*Associate Clinical Professor, Bar Ilan University Azrieli Medical School. Chair of the WPA Perinatal Psychiatry and Infant Mental Health Section. Honorary president of the World Association on Infant Mental Health (WAIMH).

Dr Miri Keren

Within the field of infant mental health, infants' socio-emotional wellbeing, as well as functional and relational symptoms, are viewed as reflecting an interplay between risk and protective factors and bidirectional influences between the infant and the environment (1). For example, persistent behavior problems and excessive infant crying can burden the parent-infant system (2), leading to parental frustration and alienation and placing the infant's well-being and development at risk (3). Utilizing attachment theory's formulation, Lyons-Ruth outlined the interplay between a mother's failure to respond to her infant's appropriate attachment needs, at times due to her own distress and developmental history, the development of disorganized attachment in her child and the emergence and continuity of child aggressive behavior (4). Thus, early interventions aim at improving the infant's wellbeing by focusing simultaneously on the infant, the parents and the parent-infant relationship (5,6). The early parent-child interventions have proven to be effective in improving parenting skills, parent-child interactive patterns, and child socioemotional well-being (7-9) as well as reducing parental stress and psychopathology (10). However, less is known about the conditions under which patterns of maladaptation persist and form continuity in psychopathology from infancy to childhood in contrast to circumstances that promote desistance in the context of early symptoms, hence, leading to psychopathology discontinuity (11).

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Several risk factors are suggested as contributing to the emergence of early infant functional and relational symptoms and their continuity into later childhood. Inadequate parenting practices and disturbed parent-infant relationships are often suggested as contributing to continued early psychopathology. For example, poor parenting during infancy, displayed as negative maternal regard for the infant during feeding interactions, was linked to externalizing problems during the preschool phase, first grade, and adulthood (12). Inconsistent parenting behaviors, lack of boundaries, and parental criticism during the early years (13), as well as parental over- or under-control were similarly linked to the emergence and continuation of disruptive behavior among children (14). Maternal over-stimulation during infancy has been shown to be linked to increased risk for depression and anxiety in children up to age 19 (15).

Parental psychopathology is also known to place children at risk for continued psychopathology (16). Early maternal depression is linked to school and peer adjustment difficulties among older children (17) and to children's internalizing and externalizing behavior problems at the ages 6-8 (18). A prospective study showed maternal PTSD symptoms to be associated with offspring's emotion regulation difficulties (19). The risk for child behavior problems is further augmented when both parents experience psychopathology (20). A study focusing on parents applying for treatment in infant mental health clinic reported that more than half the mothers and 11% of fathers complained of depressive symptoms in the clinical range (21), suggesting that parental psychopathology, and particularly depressive symptoms, are highly prevalent among parents of infants who display symptoms of emotional distress. Accordingly, disruptive child behavior during toddlerhood was associated with increased risk for persistent maternal depressive symptoms, which in turn, was associated with increased risk for children's antisocial behavior during late childhood and adolescence (22). Parental stress is linked to infant regulatory difficulties and less favorable child development at 1 year (23). Parental stress is linked with child development via poor parent-child interactions, which in turn are associated with later child internalizing and externalizing behavior problems (24). Strained and negative family functioning may also comprise a risk factor that jeopardizes child development directly and indirectly, via its potential interference with parent-child interactions and parenting behaviors (25). Exposure to adverse marital relationships raises children's vulnerability and sense of insecurity and increases the risk for maladjustment and mental health problems, including internalizing and externalizing behaviors (26). Families of infants referred to an infant mental health clinic due to infant functional symptoms, adjustment difficulties and parental psychopathology were characterized by disturbed communication patterns and negative emotional atmospheres compared with non-referred families. Poor family functioning was also associated with maternal self-reported psychopathology (27).

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The last decade has witnessed a substantial growth in the field of infant mental health and parent-infant interventions. Interventions include universal or primary preventive programs, offered to parents and infants in the general population; targeted or secondary preventive programs, offered to at-risk infants and families; and indicated or tertiary therapeutic interventions targeting symptomatic infants and parents (5). Whereas the different interventions vary in the targeted populations and treatment models and techniques, they all strive to improve the parent-child relationship as a means to enhance the child's mental health and socioemotional adjustment (5). An accompanying body of research has tested the interventions' effectiveness in improving parenting skills, parent-child interactive patterns, and child socioemotional well-being (7,28). However, a major limitation of many of these outcome studies is their reliance on relatively short-term outcome and follow-up assessments. While some studies with longer follow-up periods have reported positive, long-term intervention outcomes for mothers, children, and families, especially in terms of reduced parental stress and improved family functioning (29), others have indicated variable stability of intervention effects, depending on parental psychopathology30, family stress and duration of intervention (31). Thus, the contribution of early parent-infant psychotherapy intervention to continuity versus discontinuity of early psychopathology warrants additional research.

In a follow-up study in our own IMH clinic, Dollberg & Keren found that infancy-onset functional and relational symptoms, heightened parental stress and difficulties within the parent-infant relationship, are not necessarily a life-long destiny; yet, it may persist into late childhood and become chronic when mothers are stressed and suffer from psychopathology, and when family functioning is poor (32). A major clinical implication is the need to identify those parents who suffer from psychopathology and to continue treatment beyond the period of infancy. The findings also highlight the need for longitudinal treatment follow-up with families as some children may develop recurring difficulties.

References

1. Zeanah CH, Doyle ZP. The scope of infant mental health. In: Zeanah CH, editor. Handbook of infant mental health. 3rd ed. New York, NY: Guilford; 2012. p. 5-21.
2. Bolten MI. Infant psychiatric disorders. Eur Child Adolesc Psychiatry. 2012;22(S1):69-74.
3. Papoušek M. Resilience, strengths, and regulatory capacities: Hidden resources in developmental disorders of infant mental health. Infant Ment Health J. 2011;32(1):29-46.
4. Lyons-Ruth K. Attachment relationships among children with aggressive behavior problems: The role

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of disorganized early attachment patterns. J Consult Clin Psychol. 1996;64(1):64.

5. Barlow J, Svanberg PO. Keeping the baby in mind. In: Keeping the baby in mind. NY, NY: Routledge; 2009. p. 19-32.
6. Risholm M, et al. [Reference not listed in original references; please insert full citation if available.]
7. Bakermans-Kranenburg MJ, Van IJzendoorn MH, Juffer F. Disorganized infant attachment and preventive interventions: A review and meta-analysis. Infant Ment Health J. 2005;26(3):191-216.
8. Fukkink RG. Video feedback in widescreen: A meta-analysis of family programs. Clin Psychol Rev. 2008;28(6):904-916.
9. Bergström M, Gebreslassie M, Hedqvist M, Lindberg L, Sarkadi A, Hjern A. Narrative review of interventions suitable for Well-baby Clinics to promote infant attachment security and parents' sensitivity. Acta Paediatrica. 2020.
10. Huber A, McMahon C, Sweller N. Improved parental emotional functioning after circle of security 20-week parent–child relationship intervention. J Child Fam Stud. 2016;25(8):2526-2540.
11. Luby J, Allen N, Estabrook R, Pine DS, Rogers C, Krogh-Jespersen S, et al. Mapping infant neurodevelopmental precursors of mental disorders: How synthetic cohorts & computational approaches can be used to enhance prediction of early childhood psychopathology. Behav Res Ther. 2019;123:103484.
12. Lorber MF, Egeland B. Infancy parenting and externalizing psychopathology from childhood through adulthood: Developmental trends. Dev Psychol. 2009;45(4):909-912.
13. Rutter M, Stevenson J. Using epidemiology to plan services: A conceptual approach. In: Rutter M, Bishop DVM, Pine DS, Scott S, Stevenson J, Taylor E, Thapar A, editors. Rutter's child and adolescent psychiatry. 5th ed. London, UK: Blackwell Publishing; 2008. p. 71-80.
14. Degnan KA, Calkins SD, Keane SP, Hill-Soderlund AL. Profiles of disruptive behavior across early childhood: Contributions of frustration reactivity, physiological regulation, and maternal behavior. Child Dev. 2008;79(5):1357-1376.
15. Schmid KL, Phelps E, Lerner RM. Constructing positive futures: Modeling the relationship between adolescents' hopeful future expectations and intentional self regulation in predicting positive youth development. J Adolesc. 2011;34(6):1127-1135.
16. Fonagy P, Sleed M, Baradon T. Randomized controlled trial of parent–infant psychotherapy for parents with mental health problems and young infants. Infant Ment Health J. 2016;37(2):97-114.
17. Wright CA, George TP, Burke R, Gelfand DM, Teti DM. Early maternal depression and children's adjustment to school. Child Study J. 2000;30(3):153-68.
18. Fihrer I, McMahon CA, Taylor AJ. The impact of postnatal and concurrent maternal depression on child behaviour during the early school years. J Affect Disord. 2009;119(1-3):116-123.
19. Enlow MB, Kitts RL, Blood E, Bizarro A, Hofmeister M, Wright RJ. Maternal posttraumatic stress symptoms and infant emotional reactivity and emotion regulation. Infant Behav Dev. 2011;34(4):487-503.
20. Mäntymaa M, Puura K, Luoma I, Latva R, Salmelin RK, Tamminen T. Predicting internalizing and externalizing problems at five years by child and parental factors in infancy and toddlerhood. Child Psychiatry Hum Dev. 2011;43(2):153-170.
21. Mothander PR, Moe RG. Self-reported depressive symptoms and parental stress in mothers and fathers

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who bring their infants to an infant mental health clinic. Nord J Psychiatry. 2010;64(5):310-316.

22. Gross HE, Shaw DS, Burwell RA, Nagin DS. Transactional processes in child disruptive behavior and maternal depression: A longitudinal study from early childhood to adolescence. Dev Psychopathol. 2009;21(1):139-156.
23. Sidor A, Fischer C, Eickhorst A, Cierpka M. Influence of early regulatory problems in infants on their development at 12 months: A longitudinal study in a high-risk sample. Child Adolesc Psychiatry Ment Health. 2013;7(1):35.
24. Dubois-Comtois K, Moss E, Cyr C, Pascuzzo K. Behavior problems in middle childhood: The predictive role of maternal distress, child attachment, and mother-child interactions. J Abnorm Child Psychol. 2013;41(8):1311-1324.
25. Sturge-Apple ML, Davies PT, Cicchetti D, Fittoria MG. A typology of interpartner conflict and maternal parenting practices in high-risk families: Examining spillover and compensatory models and implications for child adjustment. Dev Psychopathol. 2014;26(4pt1):983-998.
26. Cummings EM, George MR, McCoy KP, Davies PT. Interparental conflict in kindergarten and adolescent adjustment: Prospective investigation of emotional security as an explanatory mechanism. Child Dev. 2012;83(5):1703-1715.
27. Keren M, Dollberg D, Koster T, Danino K, Feldman R. Family functioning and interactive patterns in the context of infant psychopathology. J Fam Psychol. 2010;24(5):597-604.
28. Tereno S, Savelon SV, Guedeney A. Preventive parent–young child interaction interventions to promote optimal attachment. Curr Opin Psychiatry. 2019;32(6):542-548.
29. Mckelvey L, Schiffman RF, Brophy-Herb HE, Bocknek EL, Fitzgerald HE, Reischl TM, et al. Examining long-term effects of an infant mental health home-based early head start program on family strengths and resilience. Infant Ment Health J. 2015;36(4):353-365.
30. Rayce SB, Rasmussen IS, Væver MS, Pontoppidan M. Effects of parenting interventions for mothers with depressive symptoms and an infant: systematic review and meta-analysis. BJPsych Open. 2020;6(1).
31. Lyons-Ruth K, Easterbrooks MA. Assessing mediated models of family change in response to infant home visiting: A two-phase longitudinal analysis. Infant Ment Health J. 2006;27(1):55-69.
32. Dollberg D, Keren M. Factors Contributing to Continuity and Discontinuity in Child Psychopathology from Infancy to Childhood: An Explorative Study. Clin Child Psychol Psychiatry. 2020;25(4):891–908.

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Child and Adolescent Mental Health around the World

Integrating Family Dynamics into Child Psychiatry: The Croatian Experience.

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** School of Medicine, University of Zagreb

Dra Vlatka Maršanić

Emilija Maršanić 

Introduction

Child and adolescent psychiatry is inherently systemic. Every symptom a child presents occurs within a broader ecological context, with the family at its core. Family dynamics—patterns of relating, communicating, regulating emotions, and distributing roles—shape the child's developmental trajectory, attachment patterns, resilience, and vulnerability to psychopathology. Comprehensive assessment therefore requires an in-depth exploration of the family system, not only to understand the child's symptoms in context but also to guide accurate differential diagnosis and inform treatment planning.

This article outlines (1) the role of family dynamics in diagnostic assessment, (2) the importance of integrating family-focused interventions into treatment for any child mental disorder, and (3) the Croatian experience, which illustrates how historical and systemic approaches have shaped current practice.

Assessment: Understanding the Child Through the Lens of Family Dynamics

1. The Family System as the Primary Developmental Context

From early infancy through adolescence, family interactions scaffold the development of self-regulation, stress tolerance, communication, and interpersonal expectations. Patterns of parental availability, consistency, discipline, and

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emotional attune profoundly affect attachment security—one of the strongest predictors of both mental health risk and resilience.

Because symptoms often emerge as part of the child's adaptive response to relational patterns, assessment that focuses solely on the child risks misattributing relationally driven presentations to individual psychopathology.

Key domains of family dynamics relevant to assessment:

- Attachment patterns: sensitive caregiving, emotional attunement, parental mentalization, caregiver intrusiveness or withdrawal.
- Communication patterns: clarity, conflict resolution, emotional expressiveness, triangulation.
- Family roles and boundaries: role reversals, rigid or diffuse boundaries, overprotection, parentification.
- Stressors and supports: parental mental illness, family conflict, chronic illness, socioeconomic strain, trauma history, protective community or kinship support.
- Parenting practices: consistency, limit-setting, response to distress, reinforcement patterns.
- Cultural and contextual factors: family beliefs, values, migration stress, stigma.

A careful assessment of these domains illuminates how the child's symptoms may be both shaped and maintained by family relational patterns.

2. Family Dynamics as a Core Component of Differential Diagnosis

a. Distinguishing normative from pathological behavior

Emotional outbursts, anxiety, academic decline, sleep difficulties, or somatic symptoms may reflect:

- typical developmental transitions,
- stress response to family conflict,
- grief or adjustment issues,
- or emerging mental disorders.

Understanding family functioning helps distinguish these possibilities.

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b. Recognizing how relational patterns mimic or mask psychiatric symptoms

Certain psychiatric presentations may be misinterpreted without a systemic lens:

- Hypervigilance or irritability may arise from chaotic or frightening environments, not necessarily ADHD or anxiety.
- Withdrawal or flattened affect may reflect attachment disruption or parental unavailability rather than depression alone.
- Oppositional behaviors may represent harsh, inconsistent parenting or triangulation in high-conflict divorce.
- Somatic complaints may mirror parental health anxiety or family reinforcement patterns.

c. Assessing family mental health contributes to accurate diagnosis

Parents' untreated psychiatric conditions—depression, anxiety, bipolar disorder, trauma—may alter caregiving, intensify family stress, and shape the child's clinical presentation. Without assessing parental functioning, clinicians risk overlooking essential drivers of the child's symptoms.

d. Family input improves reliability of symptom evaluation

Collateral information from caregivers provides:

- developmental history,
- observation across environments,
- clarification of symptom onset and triggers,
- understanding of family responses to symptoms.

Such information is essential for differentiating between disorders with overlapping symptomatology, such as ADHD, anxiety, trauma-related disorders, autism, and mood disorders.

3. Integrating Family Dynamics into the Formal Assessment Process

A comprehensive assessment acknowledges that the child's difficulties often reflect the intersection of individual vulnerabilities and relational environment.

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Recommended components:

- Initial family meetings to explore family structure, functioning, and concerns.
- Separate child and parent interviews to understand subjective experiences.
- Observation of parent–child interaction, particularly in younger children.
- Family history of psychiatric disorders, trauma, or relational patterns.
- Assessment of attachment, especially in preschool and latency-age children.
- Standardized tools, when appropriate (e.g., assessments of parenting stress, family functioning).
- Cultural formulation interview, adapted for family context.

Treatment: Integrating Family Support and Family Therapy into Child Psychiatry

1. Treatment Is Most Effective When It Addresses Both the Child and the System

Even when a child receives individual therapy or pharmacotherapy, the family environment continues to mediate recovery. Supportive and consistent family functioning can accelerate improvement, while high conflict, unpredictable routines, or unaddressed caregiver mental health difficulties can undermine progress.

Rationale for family involvement:

- Enhances treatment adherence (medication routines, therapy attendance).
- Improves home-based skill reinforcement (behavioral strategies, emotion-regulation tools).
- Reduces environmental triggers for relapse or symptom escalation.
- Builds caregiver capacity to respond effectively to distress, anxiety, or dysregulation.
- Repairs relational ruptures that may fuel symptoms.

2. Evidence-Supported Family-Focused Interventions Across Disorders

Across child and adolescent mental disorders, a substantial body of evidence shows that outcomes improve when treatment actively involves the family. In anxiety disorders, modifying parental accommodation and reinforcing brave behavior enhances the effectiveness of CBT. For depression, addressing family conflict, communication patterns, and caregiver mental health can significantly influence symptom improvement. In ADHD and disruptive behavior disorders,

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parent-management training and consistent home routines remain core components of care. For autism spectrum disorder, parent-mediated interventions promote communication, emotional regulation, and developmental gains. In trauma-related conditions, strengthening the caregiver–child relationship and restoring safety are central therapeutic tasks. Family involvement is also essential in early childhood disorders, where treatments such as PCIT, CPP, and attachment-based interventions focus directly on improving the parent–child relationship. Taken together, these findings underscore that regardless of diagnosis, the inclusion of family processes in treatment is not optional—it is foundational to achieving meaningful and lasting change.

3. Components of Effective Family-Focused Treatment Planning

Effective family-focused treatment integrates several interconnected elements that support both the child and the broader caregiving system. Psychoeducation helps parents understand the nature of the child's difficulties and the rationale for intervention, while strengthening parental emotional regulation and mentalization enhances their ability to respond sensitively to the child's internal experiences. Improving communication and reducing conflict within the family fosters a more supportive environment, and addressing parents' own mental health needs often proves essential for sustained progress. Establishing predictable routines, consistent behavioral strategies, and clear expectations enhances stability and facilitates generalization of therapeutic skills to the home environment. Finally, coordinating support across school, health services, and community systems ensures that the child is embedded in a network that reinforces positive change. Together, these components create a comprehensive and coherent treatment framework that maximizes the impact of child-focused interventions.

In summary, family dynamics are not peripheral—they are central to understanding, diagnosing, and treating mental disorders in children. Comprehensive assessment must include a thorough exploration of relational patterns, attachment processes, and caregiver functioning to accurately interpret symptoms and establish a reliable differential diagnosis.

Similarly, effective treatment requires engaging the family system, strengthening parental capacities, and addressing relational factors that sustain or exacerbate symptoms. When clinicians integrate child-focused and family-focused approaches, treatment becomes more aligned with the developmental realities of childhood, leading to improved outcomes, enhanced resilience, and more sustainable change.

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III: The Croatian Experience

In Croatia, the importance of understanding family dynamics in child and adolescent psychiatry has deep historical roots. Traditionally, Croatian child psychiatry was grounded in a **psychodynamic framework**, emphasizing early relational experiences, internalized object relations, and attachment-related processes. This orientation naturally placed the family—particularly early caregivers—at the center of both assessment and formulation. Over time, the field expanded to incorporate systemic family therapy, which added a broader lens that examined patterns of interaction, communication, family roles, and multigenerational influences. The integration of systemic principles enriched both diagnostic assessment and treatment planning, enabling clinicians to conceptualize the child not only through intrapsychic processes but also through relational dynamics and the functioning of the entire family system.

Today, Croatian child psychiatry services combine these traditions with modern evidence-based approaches and importantly, the national health insurance system fully covers all child psychiatric care, including family-based interventions, which helps ensure accessibility regardless of socioeconomic status. In many clinical settings—child psychiatry departments, mental health centers, and school-based services—assessment routinely include structured family interviews, joint sessions, and evaluation of parental functioning. Clinicians also recognize contextual pressures unique to Croatian families, including the influence of extended family networks, socioeconomic stressors, migration, and the lingering effects of post-war trauma. Family-based interventions such as psychoeducation, parent-management support, and systemic or integrative family therapy are widely valued and incorporated into care.

However, despite strong professional awareness and well-established clinical models, a significant shortage of child psychiatrists, psychologists, and other mental health professionals limits the capacity to provide comprehensive family-focused services consistently across the country. As a result, although integrative assessment and family interventions are standard in theory and valued in practice, they cannot always be delivered to every family with the intensity and regularity that would be ideal.

Looking forward, further development of child and adolescent mental health care in Croatia will require not only workforce expansion but also the formulation and implementation of clear national policies that define family-focused assessment and intervention as core standards of care. Establishing structured frameworks at the national level—clarifying professional roles, responsibilities, and pathways of care—would support more consistent integration of family-based approaches across clinical settings. Such policies could facilitate better coordination between health,

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education, and social services, ensure adequate time and resources for family interventions, and strengthen early identification and preventive work. By embedding family dynamics explicitly within national child and adolescent mental health policy, clinical guidelines and service models, Croatia has the opportunity to translate its strong theoretical and clinical tradition into sustainable, equitable, and high-quality care for children and families throughout the country.

Child and Adolescent Psychiatry training in Tanzania and a bit of reflection from sub-Saharan Africa: A current status assessment.

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Dr. Leonida Ngongi

Dr. Gemma Simbee

Background

It is estimated that one in seven (14%) of 10–19-year-olds experience mental health conditions globally (1), yet these remain largely unrecognized and untreated. Child and adolescent psychiatry is an area which requires increasing attention in Africa. In Sub-Saharan Africa, mental health care is inefficient, inadequate and inequitable. Most young people in sub-Saharan Africa have no choice but to live with mental disorders without receiving appropriate services or to visit traditional or religious leaders for treatment (2). A number of literatures on child and adolescent mental health

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services (CAMHS) in LMICs have reported the shortage of CAMH professionals, and limited accessibility and availability of CAMHS (3-7). In Tanzania, there is inadequacy of child and adolescent mental health services, with limited number of mental health professionals in general (6). Lack of academic training institutions/colleges focusing on child and adolescent psychiatry is one of the major setbacks in provision of child and adolescent psychiatry. Limited awareness and stigma to mental health are the major gaps to access to care for children and adolescents in Tanzania and other settings globally (8). As one of the LMIC, the current observed situation in Tanzania can also be reflected in other low-and-middle income countries across regions in Africa.

The current situation in Tanzania

Tanzania is among the East African countries. According to the official National Bureau of Statistics (NBS) population and housing census in 2022, its population was estimated to be around sixty-two (62) million.

In Tanzania, we have three established child and adolescent psychiatric clinics: one is situated in Dar es Salaam, at Muhimbili National Hospital (established in 2018); the second is at Mirembe Mental Health Hospital in Dodoma (capital city of Tanzania), which is the national and only psychiatric hospital in the country; and the third is at Bugando Medical Centre (BMC) in Mwanza region, serving the Lake and Western zones of the country.

Muhimbili National Hospital

Mirembe Mental Health Hospital

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The clinic set up at Muhimbili National Hospital allows the three preventive and treatment models (biological, psychological and social) to be moderately addressed due to presence of general psychiatry and mental health professionals (psychiatrists, clinical psychologists, occupational therapists and social workers) with lack of those who specialize in child and adolescent psychiatry specifically. The clinic at Mirembe was established early in 2020. At that time, a small building at the hospital was secured and dedicated for CAMHS. It is running daily to date but most of the time it is operating under an MD (general practitioner) due to limited number of psychiatrists; and an occupational therapist who is always there doing assessments and interventions. Another CAMH clinic was also established at BMC late 2020 when the child psychiatrist moved there from Mirembe Hospital. The clinic operates once weekly because there is no dedicated space, it is done in the same space as the general adult clinic. It is currently conducted by a psychiatrist interested in CAMH and is due to pursue her fellowship in the field. Other than the clinics mentioned, there are almost no CAMHS in the peripheral regional hospitals in the country.

Psychiatrists in Tanzania: Currently there are more than 70 general psychiatrists in Tanzania and more than 10 general practitioners who are doing their master's degree in Psychiatry. There are only two child and adolescent psychiatrists all over the country (including one recently graduated his fellowship course in UK). One general psychiatrist from Kilimajaro Christian Medical Center, a zonal hospital in the northern part of the country, is currently undergoing training in University of Ibadan in Nigeria (West African region).

Child and Adolescent Psychiatry Training in Tanzania

There is no academic institution which provide super-specialized degree in Child and Adolescent Psychiatry Tanzania. There are only two academic institutions (Muhimbili University of Health and Allied Sciences and University of Dodoma) which offer a master's degree course in Psychiatry. Child and Adolescent Psychiatry in Tanzania is only taught as modules in one of the semesters during postgraduate degree course in Psychiatry, during their second year of study. They do seminar presentations, bedside teaching sessions, observed clerkship sessions and weekly rotations in the child and adolescent clinic.

Below is an observation by Child and adolescent psychiatrist from Tanzania following an interview with one of the representatives from World Psychiatric Association- Child and Adolescent section. The interview is part of preparing a situational paper on Child and Adolescent Psychiatry training and services in Africa. She is one of the only two child and

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adolescent psychiatrists in Tanzania. She is a member and country representative of African Association of Child and Adolescent Mental Health (AACAMH).

'*On the status of training in sub-Saharan Africa, based on the statistics I know so far there are only two countries which provide child and adolescent psychiatry training, Nigeria at the University of Ibadan, Center for Child and Adolescent Mental Health (CCAMH); and South Africa at the University of Cape Town, I do not think if the status has changed. The course in South Africa started first, it was a 2-years fellowship, then Nigeria adapted the program and did some modifications by shortening the training period to 18 months (the masters in CAMH and one year for the postgraduate diploma in CAMH, I think they aimed at producing trained personnel quickly due to the high demand of the CAMH professionals in SSA as a whole. They also made the course a bit different; to be more of a leadership and public health meaning they wanted trainees to be advocates for CAMH, focusing on policy and raising awareness to the public and other stakeholders, as opposed to the South African course which is mainly clinical based. So, the Nigerian version has a very strong public mental health component. That is why when I went to study in Nigeria, the course was open for different professionals. For example, in our class of 22 students, we were 4 psychiatrists, several MDs, some special educationists and others had different backgrounds like there was someone who had done their undergraduate degree in anatomy. The year I started studying, our batch was the sixth, and the center had been gathering input from stakeholders on the course provided. The following cohorts consisted of two separate tracks from the original program: Professional CAMH (clinical super-specialization, entry requirement was psychiatrists) and the Academic CAMH (for non-psychiatrists).'*

'In Sub-Saharan Africa, as far as I know, the Nigerian and South African programs are the main ones. If there have been recent additions, we can search ... I know Kenya has a few child psychiatrists; for Rwanda and Burundi I am not really sure.'

'Concerning Tanzania, we know our own data: how many child psychiatrists we have, the child mental health services available (or not available), whether child psychiatry training exists (it does not, based on the questionnaire). We also know that during general psychiatry training, we only get rotation exposure in child psychiatry, not specialized training.'

'Apart from the CAMHS mentioned in the background section that is provided in the government hospitals, I also do provide private CAMHS at Ararat Polyclinic. The clinic is situated in the Western part of Tanzania in Shinyanga region, Kahama district. We do receive children and adolescent from nearby regions from western Tanzania. Due to shortage of human resource, we provide tele-services via mobile phones at least by case identification and advice to go for further mental health

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services in nearby facilities or if they can come straight to Ararat clinic especially those who are from nearby regions. For about a year now since the establishment of the clinic, we have been seeing a significant number of clients.'

'For training provision, as child and adolescent psychiatrist I usually go to University of Dodoma (UDOM) for 2 weeks every year to be with residents in psychiatry (those studying Master of Medicine in psychiatry) during their child psychiatry module or rotation. We usually do seminars and we spend a lot of time at the child clinic, we review and assess children and adolescents together, clerkships, case presentations and discussion. 'As a lecturer at CUHAS (Bugando) too, I usually go there for child and adolescent psychiatry lectures and some seminars, spend time with undergraduates at the clinic doing case assessment and presentations. Also, for the past 3 years there was a plan to start a master's degree course (postgraduate) in general psychiatry at CUHAS. It has not yet been approved by Tanzania Commission for Universities (TCU) but we are hoping for it to start next academic year. If it starts, I will also participate in their residency training mainly for the child psychiatry module and clinical supervision.'

So, in general, that is the Tanzanian CAMHS status. We can take it from there once we start writing the actual situational analysis paper for sub-Saharan Africa.

References

1. Institute of health Metrics and Evaluation. Global Health Data Exchange, 2021
2. https://www.afro.who.int/news/barriers-mental-health-care-africa, 2022
3. Kieling C, Baker-Henningham H, Belfer M, Conti G, Ertem I,
4. Omigbodun O et al. Child and adolescent mental health worldwide evidence for action. Lancet. 2011; 378:1515–25. doi:10.1016/S0140-6736(11)60827-1.
5. Morris J, Belfer M, Daniels A, Flisher A., Ville' L, Lora A et al. Treated prevalence of and mental health services received by children and adolescents in 42 low-and-middle-income countries. J Child Psychol Psychiatry. 2011;52(12):1239–46. doi:10.1111/j.1469-7610.2011. 02409.x.
6. Ngongi LI, Akiba CF, Kilonzo MN, Minja AA, Komba CO, Mbaga MR, et al. (2025) Barriers, facilitators and potential solutions to implementing Kiddie Schedule for Affective Disorder and Schizophrenia (KSADS) screening tool at Muhimbili National Hospital in Dar es Salaam, Tanzania. PLoS One 20(5): e0323502. https://doi.org/10.1371/journal.pone.0323502
7. Kakuma R, Minas H, Ginneken NV, Poz MRD, Desiraju K, Morris JE et al. Human resources for mental health care: current situation and strategies for action. Lancet. 2011; 378:1654–63. doi:10.1016/S0140-6736(11)61093-3.
8. Patel V, Flisher AJ, Hetrick S, McGorry P. Mental health of young people: a global public-health challenge. Lancet. 2007; 369:1302–13.

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Intentional action in CAMHS inpatient leadership.

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Dr. Edward Miller

Introduction

CAMHS inpatient units represent one of psychiatry's most demanding leadership contexts (1). Young people present with complex difficulties compounded by developmental vulnerabilities and systemic failures (2). These environments involve high relational intensity, trauma exposure, risk management, and elevated staff stress. Under such pressures, leadership may default to approaches that may be influenced by reactivity and unconscious processes. Over-reliance on reactive leadership risks creating custodial rather than therapeutic cultures, potentially replicating coercive patterns many young people have experienced (3). Staff teams are vulnerable to unconscious processes—splitting, projection, defensive routines—that fragment functioning. This paper proposes intentional action—synthesizing psychodynamic theory, Adaptive Mentalization-Based Integrative Treatment (AMBIT), and mindful leadership. Existing models offer partial solutions. Command-and-control leadership provides crisis clarity but may foster dependency. Transactional leadership ensures efficiency but can overlook emotional dimensions. Transformational leadership inspires commitment but can struggle under chronic resource constraints. Distributed leadership acknowledges diverse expertise but requires robust structures often absent in high-turnover environments. None adequately addresses unconscious group dynamics and emotional labour defining this work.

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Highfield Unit, Oxford, UK

Psychodynamic and Systemic Foundations

Bion's work illuminates unconscious institutional processes (4). Under anxiety, groups adopt basic assumption functioning: dependency (surrendering thinking to an omnipotent leader), fight-flight (uniting against threats while avoiding internal examination), or pairing (investing hope in magical future solutions). In CAMHS settings, staff may split young people into good and bad patients, adopt rigid defensiveness, or embrace magical thinking about new programs or staff members (5). Menzies Lyth described how institutions develop unconscious defensive structures - depersonalization, emotional detachment, or ritualized tasks—that temporarily reduce anxiety but ultimately undermine therapeutic relationships (6). The leadership task from this perspective is containment: holding and metabolizing system anxiety so staff remain reflective rather than overwhelmed. Systemic literacy extends this understanding. Organizational difficulties persist because leaders apply linear problem-solving to complex relational systems (7). Dysfunctional patterns arise from implicit rules and hidden coalitions that resist change. Leaders need capacity to map these structures and identify strategic leverage points, understanding that interventions evoke powerful projections—idealization, blame, hostility—that must be recognized as systemic rather than personal (8).

AMBIT: contemporary structure for containment

Adaptive Mentalization-Based Integrative Treatment (AMBIT) provides practical structures paralleling psychodynamic containment (9). Developed for youth mental health services working with complexity, AMBIT rests on four principles:

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- *Mentalizing*: maintaining curiosity about mental states underlying behaviour rather than reacting to surface presentations. When young people refuse meetings or staff disagree, mentalizing directs attention to underlying anxieties rather than assuming manipulation.
- *Team-as-platform*: explicitly recognizing the team as primary therapeutic resource requiring active maintenance (10). Practitioners cannot provide mentalizing support without a holding environment sustaining their own reflective capacity. Regular thinking together sessions create protected reflective space.
- *Systemic coherence*: addressing fragmentation across agencies. AMBIT emphasizes coordination so young people receive consistent messages rather than falling between service boundaries.
- *Adaptation*: flexibly tailoring interventions to local context while maintaining fidelity to underlying principles, requiring ongoing evaluation and learning rather than rigid protocol adherence.

AMBIT thus operationalizes psychodynamic containment, creating shared language and procedures for maintaining team functioning under pressure.

Mindful Leadership: cultivating presence

Mindfulness—intentional, non-judgmental present-moment awareness—offers complementary resources addressing regulation and relational presence (11). Mindful leadership emphasizes presence (sustained attention to current experience), equanimity (psychological balance providing stable reference points), compassion (extending kindness, responding to mistakes with curiosity), and beginner's mind (approaching situations with openness).

These qualities parallel psychodynamic containment while focusing on intrapsychic self- regulation enabling leaders to remain available for containment rather than requiring it themselves (12). Research demonstrates mindful leadership correlates with improved team communication and staff wellbeing (13).

Intentional Action: an integrative framework

We define intentional action as evidence-based, youth-informed, and values-driven decision- making sustained through reflective awareness. This captures three essential dimensions:

Evidence-based: Leadership decisions grounded in clinical guidelines, trauma-informed principles, and developmentally appropriate interventions (14), integrating echnical rationality with ethical sensitivity.

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Youth-informed: Young people as active participants through collaborative care planning, feedback mechanisms, involvement in service development, and accessible complaints processes (15).

Values-driven: Core values—dignity, compassion, respect, hope—underpin decisions, particularly when evidence is ambiguous (16). Leaders articulate explicit values, model consistency under pressure, and address breaches transparently.

These dimensions depend upon essential conditions:

- Cultural responsiveness: Attention to how power and inequities shape experiences. For example, in Aotearoa New Zealand, embedding Te Tiriti obligations and Māori wellness models is foundational (17).
- Staff wellbeing: Support through clinical supervision, reflective practice groups, mindfulness-based stress management, and post-incident debriefing reduces burnout and enhances quality (18-19).
- Systems coordination: Liaison with services, family engagement, educational continuity, and discharge planning reduce fragmentation.
- Learning culture: Structured reflection after incidents, distinguishing blame from accountability, with mindfulness encouraging openness and psychodynamic examination of resistances.

Discussion

The intentional action framework addresses key CAMHS leadership challenges by providing conceptual coherence, creating reflective capacity, centering youth voices, supporting staff resilience, and maintaining systemic awareness. However, implementation faces significant challenges such as resource constraints, regulatory pressures, high turnover, and organizational resistance.

The framework requires empirical evaluation. While constituent elements have evidence bases, their integration needs study examining staff wellbeing, therapeutic culture indicators, and young people's experiences. Leadership training must evolve to include psychodynamic content, systemic thinking, and mindfulness, supported by ongoing supervision and organizational structures.

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The framework has relevance beyond CAMHS inpatient settings—community teams, residential services, and crisis teams face similar challenges. Cross-service research could strengthen understanding of core elements and context-specific adaptations.

Conclusion

CAMHS inpatient leadership requires integration of clinical expertise, emotional intelligence, systemic awareness, and ethical clarity. Intentional action synthesizes psychodynamic understanding, AMBIT's mentalization emphasis, and mindful leadership's self-awareness cultivation.

The framework provides a coherent approach to holding difficulties thoughtfully, together, with sustained attention to young people's wellbeing. Future work should focus on empirical evaluation, training development, and cross-context applications.

Ultimately, intentional action represents an ethical commitment to remain present, reflective, and responsive - offering hope that leaders can sustain therapeutic purpose where these qualities are most urgently needed.

References

1. Malloy E, Butt S, Sorter M. Physician Leadership and Quality Improvement in the Acute Child and Adolescent Psychiatric Care Setting. Child and Adolescent Psychiatric Clinics. 2010;19(1):1-19.

2. James A, Worrall-Davies A. Provision of intensive treatment. In: Rutter's Child and Adolescent Psychiatry, 2015:648-60.

3. Bowers L, James K, Quirk A et al. Reducing conflict and containment rates on acute psychiatric wards. Int J Nurs Stud 2015;52:1412-22.

4. Bion WR. Experiences in groups and other papers. London: Routledge, 1960.

5. Menzies IEP. A case-study in the functioning of social systems as a defence against anxiety. Hum Relat 1960;13:95-121.

6. Collier J, Esteban R. Systemic leadership: ethical and effective. Leadership Organ Dev J 2000;21:207-15.

7. Senge P, Hamilton H, Kania J. The dawn of system leadership. Stanford Soc Innov Rev 2014;13:27-33.

8. Bevington D, Fuggle P, Cracknell L, Fonagy P. Adaptive mentalization-based integrative treatment. New York: Oxford University Press, 2017.

9. Fuggle P, Bevington D, Cracknell L et al. The AMBIT approach to outcome evaluation. Clin Child Psychol Psychiatry 2015;20:419-35.

10. Kabat-Zinn J. Wherever you go, there you are. New York: Hachette, 1994.

11. Hick SF, Bien T. Mindfulness and the therapeutic relationship. New York: Guilford Press, 2008.

12. Goodman MJ, Schorling JB. A mindfulness course decreases burnout among healthcare providers. Int J Psychiatry Med 2012;43:119-28.

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13. Griffin G, Martinovich Z, Gawron T et al. Strengths-based treatment for children and adolescents. J Fam Soc Work 2009;12:207-22.
14. Tisdall EKM. Conceptualising children and young people's participation. Int J Hum Rights 2017;21:59-75.
15. Schein EH, Schein PA. Organizational culture and leadership. New York: Wiley, 2016.
16. Durie M. Whaiora: Maori health development. Auckland: Oxford University Press, 1998.
17. Coffey M, Coleman M. The relationship between support and stress in forensic nursing. J Adv Nurs 2001;34:397-407.
18. West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent physician burnout. Lancet 2016;388:2272-81.
19. Wong CA, Cummings GG, Ducharme L. Nursing leadership and patient outcomes. J Nurs Manag 2013;21:709-24.

Three Decades of Connecting Child and Adolescent Psychiatric Trainees Across Borders.

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Dr Farshid Tehrani

Founded in 1993, the European Federation of Psychiatric Trainees (EFPT) connects national trainee associations (NTAs) from more than 30 European countries, coordinates exchanges across 14 countries, facilitates transnational research, and supports the development of NTAs. The EFPT is led by a Board of Directors elected annually during the European Forum of Psychiatric Trainees.

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EFPT represents all psychiatric specialties, including CAP. CAP trainees are involved in EFPT's activities and are represented at the Board of Directors through the CAP Secretary, who contributes to EFPT's CAP related strategies, represents EFPT at the European Union of Medical Specialists (UEMS) CAP Section meetings, and facilitates EFPTs' CAP-related international collaborations. In addition, the CAP trainees have their own Working Group (WG), which is a dynamic and collaborative platform to share knowledge, comparative insights, and ideas to promote the specialty.

Transnational Projects and Call for Collaboration

CAP WG provides opportunities for transnational collaboration across both Europe and beyond. This year, we are designing two new projects aiming to contribute to cohesiveness in the CAP specialty.

Our first project aims to map the diversity of psychotherapy training and its potential best practices, and to potentially contribute, in the long term, to its future harmonization. The second study aims to shed light on trainees' attitudes toward coercion, their experiences of early exposure to coercion, and the potential consequences of prescribing and/or witnessing coercive measures. Contributions from both inside and outside Europe can enrich our comparative perspectives.

Network Beyond Europe

CAP is a discipline in diverse stages of emergence, ranging from being a well-established independent specialty or subspecialty to still being developed in different countries and regions. This diversity stimulates a growing interest among trainees to exchange experiences with peers worldwide. Major events, such as the World Psychiatric Association (WPA) and International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) Congresses happening in Europe in 2026 provide a unique opportunity for the European CAP trainees to extend their connections, to network worldwide, and to build, with their peers, a shared platform for transnational dialogue, exchange, and joint initiatives.

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Educational opportunities

Bullying, Impact on Health, and Beyond: Exploring the Spectrum of Maltreatment. *Jorge Srabstein*, from United States.*

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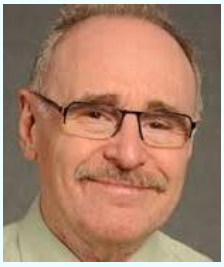
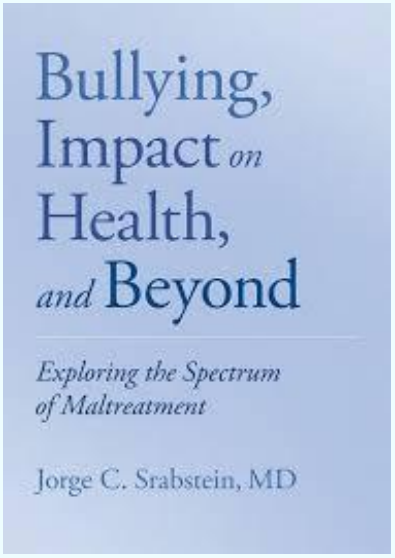


Dr Jorge Srabstein



A well-written book is one of the most important educational resources in any field of knowledge. In this issue, World CAP has the pleasure and honor of publishing an interview with Dr. Jorge Srabstein. an Argentinian child and adolescent psychiatrist, immigrated to the United States about 50 years ago. There, he was a pediatrician, then a neonatologist and, upon realizing the importance of family interactions for the proper development of children, he fell in love with child and adolescent psychiatry. He pursued his passion and developed a fantastic career, dedicating himself in recent years to writing one of the most important books about bullying: 'Bullying, Impact on Health, and Beyond: Exploring the Spectrum of Maltreatment'. The book partly reflects his work in this area throughout his career, and the World CAP is delighted to bring to readers some words from this honorable colleague.

Dear Dr. Srabstein, could you tell us about your early career and your path to child and adolescent psychiatry?

OK, so I was born in Buenos Aires, Argentina, where I grew up, where I went to medical school at the University of Buenos Aires and I graduated in medicine. At the end of 1966, I did an internship at the University of Buenos Aires Hospital Medical Centre, and in May 1969 I immigrated to the United States with the idea of doing a residency in

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pediatrics. I did one year of pediatrics at Sinai Hospital of Baltimore and then I did two more years of residency in pediatrics at Baltimore City Hospitals. That was a municipal hospital affiliated with Hopkins, and I really wanted to become a neonatologist. So, I did one year of fellowship at McMaster University in Canada followed by one year at George Washington University Hospital. After that, I stayed there and became the director for a few years of the neonatology unit.

So as a neonatologist, I published a paper in 1974 together with other colleagues at Journal of Paediatrics, raising the question, is there a kind of congenital varicella syndrome? We detected one of the first cases in the world, and that stayed there and now it's known as congenital varicella syndrome. But during that time, I was also extremely interested in mother-child's interactions. That was the psychological aspects of the newborn, the mother-infant interaction, and maternal stress during pregnancy, and all that. I was very interested in that. And that has nothing to do with intubating babies and respirators and all that. You know, it didn't. So eventually I went into psychiatry. At that time, I joined the US Army as an officer, and I did my residency at Reed Hospital – at Washington at that time.

In Washington I did my residency, general psychiatry, and then that was followed by a fellowship in child and adolescent psychiatry there. And then I stayed, I stayed in the Army for 11 years and. I was the director of the training program for Child and Adolescent psychiatry at Reed Hospital, and I stayed until 1988.

At that time, I went into private practice for a while, but I just wanted to be in academia. So back in 1998, it's going to be 27 years, I joined the Children's National Hospital faculty - George Washington University School of Medicine, and I have been with them since then.

Then you began your career as a clinician, soon became involved in managing psychiatric training programs, and about 30 years later, you joined Washington Children's Hospital. What was it like merging this clinical experience with academic tasks?

I do primarily outpatient work…I used to see like 300 new patients a year. I see them and then I follow them, you know, and I treat them. So, I have patients that I have seen for 10 years or something like that, OK. But within my experience of doing that, what became progressively of interest to me starting back in 2002, was the number of children that I saw that were coming with physical and emotional symptoms associated with the experience of being exposed to bullying in school. At that time, I read that the American Medical Association raised concerns about the serious health risk associated with this. And I started thinking about bullying and so on. And it was when, you know, the concept of bullying was not available.

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In late 1970s there was a professor of psychology in Norway that wrote a book about children that have committed suicide because they were bullied, and that raised their understanding about bullying. Until then, people knew this thing was normal. Then the newspapers started to write about that. If you go back to history, the term bullying in the past goes back to 1900 or 1910, but only in the context of this country's bullying. The other country, Germany, is bullying the United States. Russia is bullying the United States. United States is bullying other countries... it was between countries but not between people.

So, I started to publish some papers and talk in different places. And Oxford University Press invited me to write a book about this. And it took me 10 years to write the book, you know, 20 chapters, every chapter with at least 200 references.

Yes, we have heard about your impressive work on this book 'Bullying, Impact on Health, and Beyond: Exploring the Spectrum of Maltreatment'. Could you tell us a bit more about your concepts on bullying?

Bullying is not only in school, but also in the workplace, in the streets, at home between siblings, in prisons, in sports, you know, there is bullying in just everything. It just goes beyond bullying all sorts of forms of maltreatment. And it is especially within families, what you know. So, mortality prevention, detection, intervention, all the laws in the world on any form of mistreatment must then be present in the school media, in the workplace, at home, in cyberspace, in prisons, of course in the neighborhood, and even in dating,

So, what I've been doing right now it's I'm talking to different people around the world to spread the word a little bit.

This is a great initiative. I would like now to hear from you about what you would like to see happening in the global in terms of global mental health, about bullying and bullying management awareness.

Well, that has been there, the initiatives were formalized, recommended in several papers. There is a paper that was written with Bennett Leventhal and me on the World Health Organization Bulletin in which we talk about 3 levels of prevention, primary, secondary and tertiary, it's described there. Then the American Academy of Child Psychiatry and the American Psychiatric Association together have a position statement based on that, we wrote it talking about the three levels of prevention. Those were some steps.

Great! And for parents and teachers, what advice do you think is important for them?

Well, the advice is that this problem exists in all the schools, in all the social media years and that is linked to various significant health problems, health risk, not only physical like headaches, stomach aches and so on, but frequent

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depression, irritability, insomnia, nightmares, all of them happening at the same time. And of course, death through suicide or homicide. So we need to develop a whole community awareness of the notion of what bullying is, its serious risks, and how to prevent it. We need to have programs to foster the understanding in the schools about this, in health classes, and that the children should be taught about this and how to prevent it.

But that is not going to eliminate the problem. So, bullying will continue happening. In the best of circumstances, you may reduce like 30% or 40%. Therefore, it is extremely important to have the second level, the level of secondary prevention, that is when you see a patient, it doesn't matter if you're a psychiatrist or a pediatrician, that you ask about the child being exposed to bullying. You can give some examples of verbal bullying or relational bullying, psychological bullying, physical bullying and so on. And finally, it's important that it is reported to the school, to help the child that is bullied. And then the school must tell the parents to seek help from a psychiatrist to stop the bullying going on because you cannot treat the patient if the patient continues being exposed to bullying.

So finally, an important issue – and what about the treatment of the bullies?

The treatment of the bullies in the school is just advising them they cannot do it and so on. But outside, I think that they will need the combination of whatever is necessary, either therapy and or medication to stabilize their irritability, their impulsiveness, the basic needs that those kids may also have. The bullies may also have situations; morbidity associated with it. And they are kids that are both victims and bullies at the same time. And those are the ones that have the highest risk of health problems. So, I think that we have to be careful with everybody there. And the other thing that is not just bullying in school, they may be bullied in cyberspace or bullied by the siblings. They can be exposed to the parents arguments or the parents' fights or they can be exposed to seeing somebody being bullied. That can also affect the person that sees or learns because the adult lessons tell each other. So, it's a very complex situation. Also, these kids may be teenagers that starts to work, and they are bullied in the workplace – what includes other things that the workplace does that makes the person stressed out, like for instance, overwork. That's a form of mistreatment. So, I just get away from the word bullying, and I look at the whole spectrum of mistreatment that is there. It's very wide.

As we can see, these few lines reflect Dr. Srabstein's impressive development on the subject of bullying. Dr. Srabstein is an inspiration for those who wish to flow from the inspirations of clinical practice to the development of theories on the complex mental problems we deal with every day.

Thank you/Gracias Jorge!

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Meeting reports

The 25th World Congress of Psychiatry (Prague, Czech Republic, 5-8 October, 2025): The role of Psychiatry in a changing world.

Carolina Herrera-Ortiz, from Mexico.*

*Psychiatrist & Child and Adolescent Psychiatrist | State Coordinator of Mental Health and Addictions, Durango, Mexico.

Dr Carolina H-Ortiz

Prague, one of the most beautiful European cities and capital of the Czech Republic, hosted the 25th World Congress of Psychiatry the last October 2025, surrounded by a magical atmosphere with great architectural diversity; highlighting the role of Psychiatry in a changing world, it was an enriching learning experience, hosting nearly 150 associations with professionals from more than 100 countries.

The 25th World Congress of Psychiatry included 677 sessions encompassing pre-congress courses, symposia, panel discussions, meet the experts, special lectures, short oral presentations and other activities presented by over 400 speakers from around the world; these speakers addressed the most important topics in mental health; focusing on clinical practice and treatment, mood, anxiety and stress disorders, society, culture and human rights, public mental health, personality and behavioral disorders, several mental illness and others relevant subjects. This meeting dedicated 50 sessions to topics related to Child and Adolescent Psychiatry.

In the following paragraph quote, some of these presentations:

- Pre-congress course: *Parents' matter: understanding and supporting parents of young people with mental health difficulties*, moderated by Fait Martin clinical and health psychologist from United Kingdom.
- Plenary session: *Watch me grow*, presented by Professor Valsamma Eapen emphasizing the importance of early childhood, particularly the first 2000 days is critical for lifelong health and development.

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- Symposiums:
  - Childhood adversities and their lifelong impacts on development and health presented by Eeva-Leena Kataja, Johanna Klunger-Köing, Antoine Weihs and Hasse Karisson
  - Global perspectives on the Epidemiology of child and adolescent mental health: Cross-cultural patterns, risk factors and prevention strategies; presented by Viviane Koves-Masfety, Katherine Keyes and David M Ndetei.
  - Youth mental health and adverse childhood experiences: New global health research for better prevention and practice: Dabasish Basu, Linda Chiu Wa Lam, David M Ndetei, Harsimran Sansoy.
  - From infancy to adolescence in Psychodynamic psychiatry: prevention, precision and societal challenges. Fabian Guénole, Inge Seiffe-Krenke, Lisa Ouss and Luigi Janiri

And more:

- Free communications sessions: focused on relevant topics such as ADHD treatment, emotion dysregulation in children and adolescents, maternal genetic effects on child behavior.
- Meet the expert: Understanding, recognizing and the growing presence of gender identity in the consultation room with Thomas D. Steensma.
- Short oral: these presentations covered subjects such as prevalence of PTSD and anxiety, the role of sleep disturbances as a risk predictor of suicidal behaviors in adolescents, emotional burnout in elite youth athletes, adolescent friendships mental health and well-being: a neurodivergent lens, as well as various approaches to ADHD, ASD and NDD, among others.

The 25th World Congress provided us information to improve daily practice, emphasizing the importance of knowledge on issues related to neurodevelopment, as well the relevance of early diagnosis and appropriate treatment for the pediatric population; the fact that at least 50% of mental health problems are established by the age of 14 years, reminds us the priority that the field of Child Psychiatry represents.

There are few professionals specializing in child and adolescent mental health, perhaps we will always be insufficient. Sharing knowledge in this area should be one of our commitments that benefits not just health but all of humanity. Children don't represent the future; they are an essential piece of the present in the world. Caring for them, preserving and protecting their mental health, is a shared responsibility.

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The road ahead is still long and these academic meetings reduce the attention gap and give us hope and skills to provide children with better opportunities.

We look forward to continuing with a strong presence at the 26th World Congress of Psychiatry will be held in Stockholm in September 2026… See you in Sweden!

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Future meetings

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

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

The 26th World Congress of Psychiatry 2026

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The 12th Congress of the Asian Society for Child and Adolescent Psychiatry and Allied Professions

The 27th World Congress of the International Association for Child and Adolescent Psychiatry and Allied Professions

Canadian Academy of Child and Adolescent Psychiatry (AACAP) – Annual Meeting

The 19th World Association on Infant Mental Health World Congress

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