

# Perspectives in Infant Mental Health

Professional Publication of the World Association for Infant Mental Health

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## Presidential Address

### WAIMH's Infants' Rights statement – a culturally monocentric claim?

By Kai von Klitzing, University of Leipzig, Germany, President of WAIMH

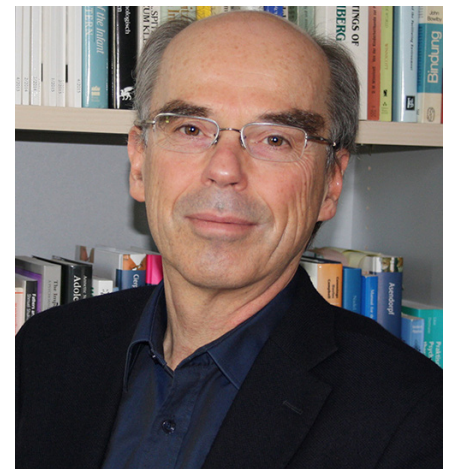
#### A case for cultural sensitivity instead of cultural relativism

Gaskins et al. (2017): A challenge to the WAIMH position paper on the Rights of Infants.

Gaskins et al. (2017) have recently challenged WAIMH's position paper on the rights of infants, in their chapter of the book "The Cultural Nature of Attachment" (Keller & Bard, 2017). The authors state that WAIMH's infants' rights motion belongs to a type of international initiative that is well-intended but limited with respect to the capacity to be implemented across diverse cultural settings. In their understanding, WAIMH – like several other organizations – relies on academic experts who:

... have reached 'scientific' conclusions about 'universal' behavior by studying a narrow range of human behavior that primarily reflects Western thought and practice, and then overgeneralizing those conclusions to the rest of the world (p. 322)

This kind of cultural bias would limit



WAIMH President, Professor Kai von Klitzing.

the validity of policy recommendations and reduce the likelihood of their acceptance in non-Western societies. For example, some of the rights that WAIMH claims for children would reduce the authority and autonomy of parents to regulate their children's care and conduct, and therefore would not be accepted in cultures where a strong commitment to parental authority (and even physical punishment) is an essential aspect of beliefs and norms. Recommendations by the rights of the infant movement could actually compromise the wellbeing of children and be harmful for families if they conflict with cultural realities for the role of children, their social support system, and the rules of socialization. The risk of harm caused by culturally monocentric approaches could increase when nongovernmental organizations (NGOs) implement services in developing countries, and even in Western countries where migration, especially from African and the Middle Eastern countries, is



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increasing in prevalence. They state that:

Uprooted immigrant or refugee families often depend on social workers and educators, who are trained in Western 'best practice' principles but often lack culturally sensitive information about their clients' specific parenting beliefs and practices (Gaskins et al., 2017, p. 325).

The authors list some examples of childcare practices that could differ significantly across different cultural beliefs and attitudes:

- a) The use of corporal punishment as a disciplinary measure;
- b) Leaving a child at home alone or in the care of another preadolescent child;
- c) Parent-child co-sleeping arrangements;
- d) Parent-child separation, for example, leaving children in the home country or sending them back to the home country to be cared for by relatives; and
- e) The role of fathers, for example, fathers being denied adequate visits to their children to ensure that children maintain a close relationship with their mothers.

Gaskins et al. (2017) recommend exercising caution especially when applying attachment theory to child-rearing practices in culturally diverse populations:

...the concept of sensitive parenting and attachment-based interventions derived from it are not necessarily appropriate for use with all families in non-Western societies or from minority communities within Western societies (p. 331).

In their view:

Attachment parenting presents a narrow portrayal of which caregiving practices are 'natural' to humans as a species, despite scholarly disagreement about which practices actually characterize care of the young and the extraordinary range of actual caregiving practices throughout the world in which infants thrive (p. 331).

In the authors' view, achieving social trust

in the preschool classroom that creates a positive social and emotional climate for early childhood education seems to be a better contextual quality indicator than simply warm teacher-child attachment relationships, which vary in how they are understood and recognized in diverse cultural communities.

The authors recommend that practitioners adopt a culturally sensitive attitude when working with populations from diverse cultural backgrounds. Instead of applying their own cultural beliefs in an indiscriminate way, for example to evaluate rearing practices in migrant populations, they should ask "Why is the parent following this particular practice?" or "Is there a reason that motivates this behavior, perhaps stemming from a belief in particular socialization practices?" Furthermore, they recommend more research efforts to build an evidence base for practices that may vary across cultures. The study of cultural differences should become a priority in attachment research as well as in intervention studies. "(...) Unless culture is incorporated into the empirical database, culture will never find its ways into policy" (p. 332).

## Response to Gaskins et al. (2017): A case for cultural sensitivity instead of cultural relativism

Certainly it is to the credit of the authors, as well as of Heidi Keller's group, that they draw our attention to the danger of the culturally monocentric approaches of Western-based research traditions and especially of an uncritical transfer of Western attachment research findings to child-rearing practices and policies in diverse societies. But:

1. Are different ways of treating infants indeed equally valid in leading to a positive developmental pathway if they are only embedded in the culturally based beliefs of diverse populations (cultural relativism)?; and
2. Can research, practical and culturally sensitive though it may be, really provide us with enough confidence that a particular rearing practice is protective for the development of mental health, or whether being raised in a certain environment ought to be identified as a risk factor?

The claim that universally valid rights of children, especially of infants, can be determined seems to be challenged by the idea that the beliefs, values and practices

of child rearing should be grounded in the parental culture, rather than being judged against any global criteria. I would like to discuss this culturally relativistic approach by addressing three essential rights defined by the WAIMH position paper:

1. Infants' need for reliable and emotionally responsive care from continuous caregivers;
2. The harm of violent care; and
3. Equality of rights regardless of gender.

### Continuity of good care

The satisfaction of this need in early childhood cannot be taken for granted in many parts of the world. In Western societies themselves there has been a fundamental change in attitudes towards good care practices over recent decades. For example, until the 1980s in both the USA and Europe, infants were separated from their parents when they were admitted to hospital with serious illness, sometimes for many weeks or even months. It was believed that the hygiene standards of a hospital required parents to be excluded from the children's ward, and that young children would suffer more if they were too close to their parents. The ground-breaking work of René Spitz, James & Joyce Robertson, John Bowlby and many others made the public aware of infants' emotional need for continuous care from sensitive caregivers, and that early separation is a major risk factor in mental health development. Since then, paediatric care practice has changed dramatically.

Giving consistent focus to the emotional needs of young children has changed cultural beliefs and rules in many parts of the world, even though there might be culturally rooted differences in the structure of caregiver settings (e.g. mother, father, family, institutional settings). However, there are still many places and situations in the world where young children are separated from those to whom they relate most closely. For example, in Romania during the communist era, infants were placed in inadequate children's homes and suffered from the absence of continuous caregivers; migration also often leads to family dispersion, with traumatic experiences of separation for infants; leaders of rich countries may decide to separate young children from their parents to make a political point, etc.

All these separation procedures may be justified by good reasons: ideologically rooted beliefs in optimal childcare practice, poverty, the search for a better life, border control etc. Cultural sensitivity should lead

us to ask the parents or other responsible adults about the reasons for their practices, and to treat them with understanding. On the other hand, we clearly also need to look at these practices through the lens of young children's emotional needs and indicate the consequences for mental development.

### Violent care

This issue is already more complicated, because there seems to be no clear-cut distinction between the physical abuse of children and culturally accepted methods of education using corporal punishment. Even within Western societies there are differences: 57 states (including Germany, Finland, Spain, Brazil, Nepal and Kenya) have officially prohibited the corporal punishment of children, while by contrast in all of the United States and in most African and Asian nations, corporal punishment by parents is currently legal. It is also legal to use certain implements such as a belt or paddle. There is clear empirical evidence that physical abuse is harmful for children and presents a risk to mental and physical health. It is an open question whether there are any forms of acceptable violence, like spanking, in the context of the parents' cultural backgrounds as a measure of ensuring parental authority. This question cannot be solved by empirical research alone. It is also a question of social values. To me it seems clear that in societies in which violence is an accepted method of solving conflict, violence towards children is more tolerated as well. There may be understandable reasons why violence as an educational method might be justified: ensuring parental authority, supporting discipline in uncertain circumstances etc. Cultural sensitivity is required to understand the backgrounds of violent parental practices. It is not at all justified to counter such parental attitudes with arrogance and moral condemnation. On the other hand, it seems to be problematic that diverse cultural norms and values are supposed to be sufficient reasons to deny children the right to physical integrity.

### Equality of rights regardless of gender

This might be the most complicated issue because gender roles and gender-specific care of children are largely rooted in cultural backgrounds and often the religious beliefs of adults. Developmental research teaches us that there are different developmental pathways for male and female development (for example

Tremblay & Cote, 2019, in a special issue of the *Infant Mental Health Journal*), but it is still quite unclear which are the biological and which are the social roots of these differences. The roles of male and female individuals are quite diverse in different societies; in particular, the social participation of girls and women in public life is completely different in different parts of the world. These differences again cause problems especially when populations from diverse cultural backgrounds join together as a consequence of increasing migration. It might be necessary for cultural values about gender roles to be newly negotiated at some point in Western countries as well. Cultural sensitivity means that we listen carefully and try to understand the attitudes of parents from different cultural backgrounds, for example about their ways of treating boys and girls. But this cultural sensitivity does not relieve us of the necessity to look after our children's developmental needs for increasing participation in social life, regardless of whether it is male or female development.

Cultural relativism bears the danger of relativizing the essential rights of young children. The need for adequate and continuous sensitive care is based on the dependence of children during their early years and should be defined as an infant's right because the satisfaction of this need has far-reaching consequences for further development. The right to be protected from violence is also essential, because care without violence can mediate children's capacity to regulate their own aggressive impulses and to enter into social cooperation with other humans. Likewise, physical integrity and social participation can be seen as an important right of children independent of their gender. Doubtless the way these rights are implemented in concrete social rules depends on context.

Abramson B. (2006) has emphasized that most of the rights of children are context-dependent, which means that they always require balancing. Some of the rights of children may conflict with the fundamental rights of other stakeholders in particular social and cultural contexts, such as the rights of parents to guide their family life with parental authority. This kind of conflict requires interests to be balanced. Balancing the competing interests requires decision-makers to truly value the people who are in the conflict. As young children are not able to express their own interests, they need global agencies that try their best to define these interests and to seek agreement among the world community on which rights are really essential for children.

This is how I understand the work of the *Committee of the Rights of the Child*: WAIMH tries to specify these rights for infants. Only if we define these rights against a background of a discussion of values and our developmental knowledge, will we be able to balance these rights with the rights of others or other rights, depending on the cultural context. For example, I would claim that there is a difference between a situation in which the president of a wealthy superpower violates the rights of children not to be separated from their parents because of political interests, and one where a Syrian father or mother decides to separate from his/her young child in order to enable him/her to live under safe conditions. If we do not define the rights of infants and do not claim the global validity of these rights, the infants' need will be unheard and there will be no social need to include these rights in a fair social balance and agreement. We should therefore oppose culturally relativistic attitudes towards children's rights but employ as much cultural sensitivity as possible when we implement them in real social and cultural contexts.

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## WAIMH Executive Director Address

By Kaija Puura, Tampere, Finland, WAIMH Executive Director

Dear WAIMH members and colleagues,

With the year 2019 being still new, maybe it is good to take a look back at the year 2018. For me last year was even a bit more busy than usual with the preparations of the Rome congress during the spring, and after that with several changes happening in the Office. Times of transition are often challenging. We know that changes are necessary, and yet we feel some regret for having to go through them. Becoming the Executive Director of the WAIMH was – in addition of being an honor – a necessity, and yet carried a bit of sadness for having to say goodbye to my long time boss and friend, Pälvi. Growing into the new role as the ED of WAIMH is a bit like wearing a new pair of shoes: takes time before you feel comfortable walking in them. The big questions for me are how I can serve WAIMH and how can I promote Infant Mental Health in the best way as the ED.

One of the best things of our organization is that it puts you into contact with lots of nice people who are working for Infant Mental Health in their own countries and areas. Through WAIMH people from different countries can reach out to each other and ask for collaboration in providing education, training or even patient consultation. So, thanks to the initiatives of my WAIMH friends and colleagues I found myself being part of workshops in Infant Mental Health issues in congresses for people working with children and adolescents in July and with adult psychiatry in September. Even though the number of people attending these workshops was counted rather in tens than hundreds, those attending were genuinely interested in hearing about babies and their parents, and also eager to share their own experiences. My hope is that each of these colleagues would in turn talk about what they had learned with their own coworkers and get them interested in Infant Mental Health as well.

I also had the chance to do two longer training trips. In October I was invited to Cape Town, South Africa to teach a multidisciplinary group of professionals for a few days. We worked together learning how to detect signs of infant distress by observing the infant, and what it might mean in the local context. It was wonderful



WAIMH Executive Director, Professor Kaija Puura.

to experience how skilled, dedicated and enthusiastic the Cape Town trainees were and how easy it was to talk with one another. My year ended with a trip to Japan, where thanks to the perseverance and work of many Japanese colleagues, the municipalities now have to offer health care services to all families with infants in the similar manner as in Nordic countries. The new services have been named after Finnish well-baby clinic “neuvola”, or “neubora” as they are called in Japan.

My hosts had organized a one-day training in Tokyo and in Osaka for primary health care nurses working in these new services. Together we practiced supporting parents in the primary care services and talked about how babies develop and why promoting Infant Mental Health is important. In Tokyo I also had a wonderful experience of visiting a child protection centre and being part of a case consultation. And just like in Cape Town, meeting and talking with the local professionals involved in Infant Mental Health was really inspiring. It is one of the wonders and great gifts of this work, finding good people all over the world sharing the same goals and giving you hope, too. These encounters and the nourishment they provide keep us going all around the world.

Kaija

# From the Editors

By

Maree Foley, Switzerland,

Deborah J Weatherston, USA

and Hiram Fitzgerald (USA)

This Winter (2019) edition of WAIMH *Perspectives in Infant Mental Health* includes reviewed and accepted papers since the Fall (2018) edition. Each paper calls attention to and consideration of what WAIMH members and allied infant mental health colleagues around the world are thinking, doing, and writing about.

Before introducing the papers in this edition more fully, we want to update you about the editorial team as well as two *Perspectives* initiatives that are being conducted in collaboration with the WAIMH office staff: a) a pending *Perspectives in Infant Mental Health* WAIMH member survey; and b) the online availability of past editions of *The Signal*.

For newcomers to WAIMH, *The Signal* was the former name of *Perspectives*. Furthermore, Emily Fenichel, named *The Signal* after an international contest. At the time Emily was Associate Director of *Zero to Three* and was also the Editor of the *Zero to Three Journal* from 1992 – 2006.

## The current WAIMH Perspectives Editorial team

This issue marks the beginning of a transitional editorial team. As of January (2019), Maree Foley shifted her role from Assistant Editor to Editor of *Perspectives*. During the 2019 transitional year, Deborah Weatherston, the previous Editor, has agreed to serve as Associate Editor for 2019, and Hiram Fitzgerald has agreed to serve in the same capacity until June 30, 2019. At this time, he will retire from his professional career and extraordinary long service to WAIMH. Minna Sorsa continues in her role as Production Editor.

During this transition year, we are seeking two people who are interested in joining the editorial team as Associate Editors. If you are interested and want to know more about what this role entails, please contact Maree Foley ([maree.foley@xtra.co.nz](mailto:maree.foley@xtra.co.nz)).

## WAIMH Perspectives in Infant Mental Health survey

In March-April all WAIMH members will be invited to participate in an e-mail survey about future directions for *Perspectives in Infant Mental Health*. Over the past few years our WAIMH publication has evolved into an open source online resource that includes both regular posts as well as an online quarterly publication. Given these recent changes, we are keen to hear from you about your ideas and experiences about the future of *Perspectives*. Thank you in advance for your participation.

## Previous Signal papers available online on the WAIMH website

Over the past year, Minna Sorsa (WAIMH Senior Administrator) and Sari Miettinen (WAIMH Administrative Assistant) have been tirelessly uploading previous paper copies of *The Signal* and *Perspectives* into an electronic format. Minna and Sari are continuously working to keep the *Perspectives* website updated and over time plan to publish all previous issues of *The Signal* and *Perspectives*, onto the WAIMH website.

## This Winter (2019) Edition

This Winter (2019) edition begins with a *Presidential Address* by Kai von Klitzing (University of Leipzig, Germany) President of WAIMH. In this address Kai summarizes a commentary from Gaskins et al. (2017) who wrote a chapter, "Implications for policy and practice" focusing on cultural bias in the field of attachment and early childhood. Kai then provides his perspective, anchored in WAIMH's ongoing work to headline infant rights across multiple levels, from the family and community, through to national and multilateral global commitments. The Presidential address is followed by the *WAIMH Executive Director Address* by Kaija Puura. Kaija reflects on her initial months in the role and highlights its capacity for membership connection and global outreach.



Editor of Perspectives, PhD Maree Foley.

Next is a paper about *The Colorado Association for Infant Mental Health* (CoAIMH) by Board President, Ous H. Badwan (Psy.D., M.F.T.). CoAIMH has been a WAIMH Affiliate since 2002 and has been an official affiliate of The Alliance for the Advancement of Infant Mental Health (the Alliance) since 2010. This report reflects on their mission, vision, and a recent Alliance-CoAIMH initiative; hosting the Third Annual Reflective Supervision and Consultation (RS/C) in 2018. The paper also reports on the *Colorado Foundations of Infant and Early Childhood Mental Health for Early Childhood Professionals and Partners* (Colorado Foundations). This is a CoAIMH initiative; a 9-module foundational course, designed to support training and competence in Colorado's infant and early childhood mental health workforce. Finally, this paper highlights the diversity of professional membership within affiliates with the majority of their members working in non-clinical settings with families/other caregivers and young children.

The CoAIMH paper is followed by a paper entitled: *The Surgeon and the Baby*. This paper is a personal reflection from Heinz Rode, a paediatric surgeon. Heinz is an Emeritus Professor, at the Red Cross War Memorial Children's Hospital and University of Cape Town, South Africa. Heinz reflects on an over 40-year career as a paediatric surgeon, caring for sick babies and their families. He identifies, with compassion and integrity, four primary phases of his interactions with the baby and family: (1) Meeting the sick neonate

and family; (2) Establishing a diagnosis and prognosis; (3) The neonate as the patient with an organ to be operated upon ["Baby Joe the patient" becomes Baby Joe as a "liver"]; and, (4) The aftermath and the future for baby and family.

Next is an article centered on a response by a reader of *Perspectives*, Grace Whitney. Grace, responded to the editors regarding a previously published article by Wendy Bunston: How Refuge provides refuge to Infants: Exploring how 'refuge' is provided to infants entering crisis accommodation with their mothers after fleeing family violence (*Perspectives in Infant Mental Health*, Vol.26. No. 4, Fall, 2018). As a result of this dialogue, Maree Foley, Deborah Weatherston and Grace Whitney wrote a short article that aims to contribute to the conversation about infants and their families who are homeless.

What follows is a *Featured Report* that we hope will be of interest to our readers who are engaged with the area of infants and homelessness. We provide a link to the following report: Hogg, S., Haynes, A., Baradon, T., and Cuthbert, C. (2015). *All Babies Count report, An unstable start: Spotlight on homelessness*. NSPCC in partnership with the Anna Freud Centre, London, UK. We also provide a link to a slide presentation, oriented towards practitioners, which summarizes key findings from this report.

Next is a previously posted paper from our *Signal archive*: "The era of using video for observation and intervention in infant mental health", by Nicole Guédeney and Antoine Guédeney. It was published in *The Signal*, 06/15/2010. The paper begins with a short history of the work of the early "cinema" pioneers. It then reviews the role of video in providing a new lens on infant development and early interactions. It concludes that the use of home videos has benefited preventive work with infants and families.

What follows is a report for the *WAIMH Affiliates Council* by Anna Huber (WAIMH Affiliate Council Chair) and Jane Barlow (WAIMH Affiliate Council Representative). They report on a recent initiative within the Council which is to establish a working group to help progress the development of a set of guidelines for local infant mental health groups who seek to become WAIMH Affiliates.

Finally, we have re-posted the news from the WAIMH Office concerning the update on the online Signal archive, available to all on the WAIMH website: *Read and browse past issues of Perspectives in Infant Mental Health*. Currently, issues can now be accessed online, with past issues

dating back to 2007 currently available by following this link: <https://perspectives.waimh.org/perspectives-archive/>

In addition, past articles are also available online in text format, which in turn can be shared: <https://perspectives.waimh.org/>

As the WAIMH *Perspectives* editorial team, we thank each person for their interesting

and thoughtful contributions. We welcome submissions from the field that challenge the way we think about infants, families, culture, and community, and offer fresh perspectives on policy, research, and practice. As always, we invite comments in response to what is published in WAIMH *Perspectives in Infant Mental Health*.

## Perspectives Outreach Calling all Infant Mental Health Professionals!

It is especially thought provoking to understand that every infant and family is affected by forces far beyond their reach - forces that may strengthen or hinder social, emotional, and relational health. A truly global organization, WAIMH invites professionals from around the world to contribute to its quarterly, open-source publication, WAIMH Perspectives, offering insights into the ways of seeing and being and working in diverse contexts, cultures and communities with infants, very young children, and their families.

We are calling for:

- commentary, field reports, case studies, conceptual or theory building papers,
- research articles, book reviews, news from WAIMH affiliates and (when proper permission can be obtained) adaptations of previously published articles

Our shared hope is that Perspectives will offer a space for interesting observations and articles around the world that promote reflection and interdisciplinary discussion.

We publish Perspectives quarterly throughout the year. An open-source publication, members and others interested in infants and infant mental health have access to current and archived issues. The format for each article may be quite informal or formal, but within these guidelines:

Double spaced

12 point font

250 words per page

APA, 6th edition for style

Articles of varying length are welcome. However, length should not exceed 10 pages, word format

Send pictures and tables in separate files, with a resolution of 72 pixels/inch

Send your submission to: WAIMH Perspectives Editor, Maree Foley,

[maree.foley@xtra.co.nz](mailto:maree.foley@xtra.co.nz)

This paper is about *The Colorado Association for Infant Mental Health (CoAIMH)* by Board President, Ous H. Badwan (Psy.D., M.F.T.). CoAIMH has been a WAIMH Affiliate since 2002 and is an official affiliate of The Alliance for the Advancement of Infant Mental Health (The Alliance), since 2010. This report reflects on their mission, vision, and a recent initiative where they partnered with The Alliance to host the Third Annual Reflective Supervision and Consultation (RS/C) in 2018. The paper also reports on the *Colorado Foundations of Infant and Early Childhood Mental Health for Early Childhood Professionals and Partners (Colorado Foundations)*. This is a CoAIMH initiative; a 9-module foundational course, designed to support training and competence in Colorado's infant and early childhood mental health workforce. Finally, this paper highlights the diversity of professional membership within affiliates with the majority of their members working in non-clinical settings with families/other caregivers and young children.

By Ous H. Badwan (Psy.D., M.F.T) CoAIMH Board President, Colorado, USA

The Colorado Association for Infant Mental Health (CoAIMH) is a not-for-profit membership organization that was founded in 2001, has been an official affiliate of the World Association for Infant Mental Health (WAIMH) since 2002 and is an official affiliate of The Alliance for the Advancement of Infant Mental Health (the Alliance) since 2010. The link for CoAIMH is as follows: [www.coaimh.org](http://www.coaimh.org)

## Mission and Vision

CoAIMH's *mission* is achieved through the development and support of Colorado's infant and early childhood workforce, along with advocacy for public policy matters that impact young children. CoAIMH's *vision* is a strong community of providers, policy makers, and

# Colorado Association for Infant Mental Health: Profile and Initiatives



researchers that consistently prioritizes the relationships between young children and their caregivers.

## Membership

Membership in CoAIMH is open to individuals of all disciplines and to all those living in Colorado who provide evidence of some expertise in and dedication to the field of infancy and early childhood. CoAIMH's membership represents a wide variety of professionals who work with young children and families, including mental health clinicians, early childhood mental health consultants, early interventionists, home visitors, university faculty, child care providers, private practice therapists, physicians, and other allied health practitioners. Most of CoAIMH's members work with families/other caregivers and young children in non-clinical settings and are part of the large child-serving system in Colorado. CoAIMH is currently run by a 7-person volunteer board and 1 part-time contractual employee.



Board President, Ous H. Badwan, Psy.D., M.F.T.

## CoAIMH and The 3rd Annual Reflective Supervision/ Consultation Symposium: Mining the Depths, An Exploration of Equity through the Reflective Process (2018)

CoAIMH, in partnership with The Alliance for the Advancement of Infant Mental Health (The Alliance), sponsored the Third Annual Reflective Supervision and Consultation (RS/C) in 2018. The annual RS/C Symposium is an opportunity for mid-career and advanced practitioners to deepen their understanding of reflective supervision and consultation through short presentations by invited speakers, the experience of observing reflective supervision sessions, and small group-

guided reflection and discussion on the larger group experience. The Symposium is also an opportunity for the Alliance to recognize the work of leaders in the field and to bring research and challenges to our attention through invited speakers.

Recognizing a lack of diverse representation and a gap in attention given toward issues of diversity and equity in the infant and early childhood field, CoAIMH chose to focus the event on these issues and thus titled the Symposium: *The 3rd Annual Reflective Supervision/ Consultation Symposium: Mining the Depths, An Exploration of Equity through the Reflective Process*. The overall purpose of this event was to offer a space where participants could bravely and openly discuss issues of equity, race, cultural diversity, and intersectionality within the context of reflective supervision in the infant and early childhood field. CoAIMH was thrilled to welcome Dr. Eva Marie Shivers, Founder and Director of the Indigo Cultural Center in Phoenix, AZ as the event's theme advisor and keynote speaker, as well as over 165 infant and early childhood professionals from across the country to the event.

CoAIMH and the Alliance did not expect to solve the problem of racial inequity during these three days but felt it was imperative to bring a conversation to the forefront. Many reactions about the event have been expressed and raised many questions, both from attendees and from stakeholders. In the work of addressing racism and social inequality there is often this difficulty - who takes on this work, oppressed or the oppressor? When do we work separately in groups of affiliation and when and how do we come together? CoAIMH was grateful for the opportunity to create dialogue around issues of equity, race, cultural diversity, power, and privilege in the infant and early childhood field. Planning for and hosting the event has led to an increased commitment of keeping these important issues at the forefront of our strategic plan.

## Colorado Foundations of Infant and Early Childhood Mental Health for Early Childhood Professionals and Partners

To further support the continued training and support of Colorado's infant and early childhood mental health workforce, CoAIMH developed a 9-Module foundational course, called *Colorado Foundations of Infant and Early Childhood Mental Health for Early Childhood Professionals and Partners (Colorado Foundations)*. *Colorado Foundations* is unique in its ability to promote a shared understanding and common language of infant and early childhood mental health principles to all professional who touch the lives of infants and toddlers and their families. CoAIMH is currently revising *Colorado Foundations* based on 2017 pilot evaluation data. With the support of funding from the Buell Foundation, the revised curriculum is currently being linguistically translated into Spanish while bilingual and bicultural Master Trainers are being trained to deliver the curriculum to monolingual (Spanish-speaking) or bilingual infant and early childhood professionals. These strategic steps toward increasing CoAIMH's representation and capacity to deliver culturally-responsive programs were directly informed by CoAIMH's experience planning for and hosting the 2018 RS/C Symposium.

## CoAIMH and ongoing professional development opportunities

In addition to *Colorado Foundations*, CoAIMH continues to provide bi-annual professional development opportunities on a variety of topics related to the field of infant mental health. CoAIMH also coordinates the Infant Mental Health



Photo of 3rd Annual Reflective Supervision /Consultation Symposium.

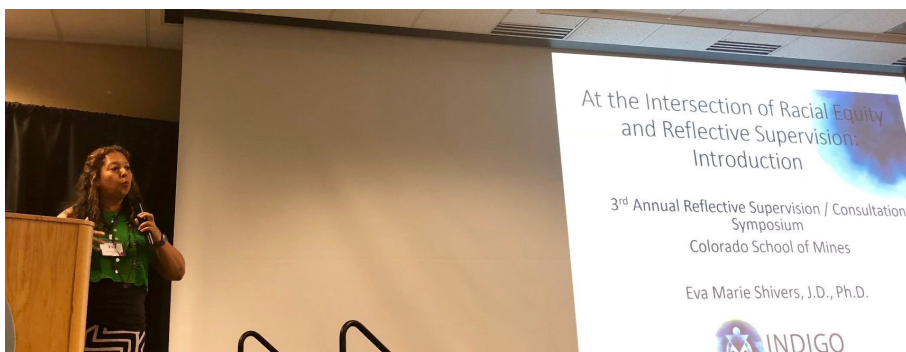
Endorsement (*The Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health: IMH-E*) in the state of Colorado. CoAIMH coordinates a variety of other services within our state.

## Looking Ahead

Moving forward, CoAIMH is committed to:

- a) offering a platform that cultivates conversations about diversity and the development of culturally-responsive programs (to better reach underserved and diverse populations); and
- a) providing leadership opportunities for professionals who represent a diverse audience.

CoAIMH's current challenge is an active transition from a volunteer to a staff-run organization. After recently completing a 3-year business plan, we intend to hire an Executive Director during this calendar year. Our current proposal for funding to support this new position has been reviewed and approval is currently pending. CoAIMH's growth has been greatly supported and celebrated within our state. At the same time, this growth has come with challenges that are particularly related to the capacity of the current structure to sustain CoAIMH's current operational duties on a day-to-day basis.



Eva Marie Shivers, J.D., Ph.D addressing the 3rd Annual Reflective Supervision /Consultation Symposium.



This paper is a personal reflection from Heinz Rode, a paediatric surgeon. Heinz is an Emeritus Professor, at the Red Cross War Memorial Children's Hospital and University of Cape Town, South Africa. Heinz reflects on an over 40-year career as a paediatric surgeon, caring for sick babies and their families. Heinz offers a rare view into the heart of the paediatric surgeon. He identifies with compassion and reflective insight four primary phases that guide and help to navigate his interactions with the baby and family: (1) Meeting the sick neonate and family; (2) Establishing a diagnosis and prognosis; (3) The neonate as the patient with an organ to be operated upon ["Baby Joe the patient" becomes Baby Joe as a "liver"]; and, (4) The aftermath and the future for baby and family. This article provides a shared reflective space between the surgeon and the Infant Mental Health (IMH) specialists who journey with these babies and their families, often in parallel. This paper provides a platform from which to engage in a conversation about how as IMH specialists we can also consider the paediatric surgeon and hold them in mind as part of the baby family world.

By Heinz Rode, South Africa

Emeritus Professor, Red Cross War Memorial Children's Hospital and University of Cape Town, South Africa

"Please exercise the greatest gentleness with my miniature tissues and try to correct the deformity at the first operation. Give me the blood and the proper amount of fluid and electrolytes; add plenty of oxygen to the anaesthesia, and I will show you that I can tolerate a terrific amount of surgery. You will be

## The Surgeon and the Baby



surprised at the spread of my recovery, and I shall always be grateful to you." (Entrance to operating theatre at Red Cross War Memorial Children's Hospital from *The Surgeon and the Child*, Willis J. Potts).

This is a very personal reflection on my career as a paediatric surgeon over a period of 40 years caring for sick babies and their families. I was fortunate to have entered children's surgery when it was still in its infancy and have, over the years, observed a dramatic improvement in the survival of infants that was previously thought not possible.

Paediatric surgery as a specialty started late and had to wait until the second half of the 19th century, when Virchow and Claude Bernard gave medicine a scientific basis. It took a long time before we appreciated the complexity of the developing foetus as well as the developing anatomy in infants and children regarding their physiology and disease processes. It is now possible to operate safely with a good outcome on the smallest of children with the most complex pathology, with most eventually enjoying full and productive lives as they grow up.

However, there are dark clouds on the horizon. The complexity of modern medicine, which has given us these spectacular results, has also in some way been responsible for dehumanizing medicine and directing our personal attention away from the family and sick child. With new diagnostic and therapeutic developments, modern medicine is

increasingly encroaching on, and at times displacing, our interactions with the sick child and her/his parents.

The care of infants requires judgement, knowledge, experience and wisdom. There remain, however, some 'things' which cannot be defined, characterized, or quantified, which are greatly influenced by one's own experience with anxious and concerned parents and their sick babies with life-threatening conditions.

I will not concern myself with the technical aspects of the various surgical procedures to correct congenital abnormalities. Instead, I focus on four distinct, yet intensely integrated processes, involving the sick infant and family.

### The role of the paediatric surgeon can be separated into four phases:

1. Meeting the sick neonate and family;
2. Establishing a diagnosis and prognosis;
3. The neonate as the patient with an organ to be operated upon ["Baby Joe the patient" becomes Baby Joe as a "liver"]; and
4. The aftermath and the future for baby and family.

## Phase One: Meeting the sick neonate and family

During the first phase new-born surgery is usually performed to correct a congenital anomaly that may affect the baby's survival. The family has not known the infant as a separate individual before birth and the mother in particular faces a difficult and very stressful situation. Unfortunately, as the surgeon, I have seldom met the family or spoken to the mother preoperatively, as this is often an emergency situation as the baby is abruptly separated from his/her mother.

Even in the physical absence of the mother, I have found it essential to have a conversation with her either directly or by phone, to try to lessen her anxiety, despair and even hostility towards me. All these emotions are quite understandable as becoming the parents of a sick baby, being confronted by the diagnosis, and facing an uncertain future must be very unsettling. Parents must therefore be helped to make sense of their baby's illness and the effect it will have on their parenting. They remain in the pivotal role and any medical decision must be in the best interest of both the baby and his/her parents.

When a baby is born with a congenital abnormality, five possible outcomes can be anticipated; these are in the surgeon's mind when speaking with the parents. There are those babies with the potential for total recovery; those that would lead a near normal life; those that would require permanent supervision and medical care; those that will be left with serious physical and mental damage; and finally, those with anomalies that are incompatible with life.

To convey this information to already distressed parents is challenging and we, as surgeons, are inadequately trained for this task. Preparing the family for what lies ahead, is thus a personally rewarding yet also a stressful process.

The surgical procedure needs to be explained in detail in order to lessen any misunderstanding, thereby reducing fear, anxiety, and instilling confidence. Compassion is the essence of what the grieving parents expect from their paediatric surgeon as well as the empathy he/she conveys towards their anguish.

Even as a surgeon who has dealt with many crisis situations, one remains human and inevitably becomes emotionally involved with the family. Being a father myself, increases my understanding of the dynamics of uncertainty, hope, and expectation that parents have. Images based on all my collective previous experiences about the possible

consequences of the pathology and the immediate and long-term outcomes are vivid in my mind when talking with the parents. This may result in an emotional overlay, and my anxiety, particularly if the baby or child is of the same age as my own, may cloud my judgment and I may unconsciously consider unrealistic options to help lessen the gravity of the situation. To a great extent this period can be ameliorated by being aware of my emotions and by devoting adequate time and attention to the parents and their concerns, always with the baby at the centre of our focus.

## Phase Two: Establishing a diagnosis and prognosis

The second phase is the transition from meeting the parents to the examination of their baby, after transfer from the maternity hospital. Admission to an ICU in preparation for a major operation is usual. The parents now enter a space that is foreign, mysterious and frightening to them. Even the baby faces a great unknown. My engagement changes from the sympathizing doctor to an objective, unemotional examination of the new-born. The focus is now entirely on the baby. It requires many months and years of experience to recognize the significance of a baby's helplessness and cry, without the benefit of questions and answers to evaluate his/her condition.

Although the diagnosis could have been suspected prenatally or after the clinical examination after birth, the final diagnosis often requires further radiological and other invasive procedures. The baby then again enters a different environment of high technology where his/her diagnosis will be confirmed, thereby determining the need for an operation and the prognosis.

What follows is a crucial period. As a surgeon, you have a great responsibility to the baby entrusted to your care. I will now discuss in full detail, and in such a manner that the anxious parents can understand the pathology, the aim of the impending surgical procedure and the aftermath. This cannot be left to others as they could minimize or misrepresent the full context of the diagnosis and the gravity thereof. It is, and always was, my responsibility. It is often very helpful to use a simple sketch to demonstrate the pathology and the corrective surgical procedure.

## Phase Three: The neonate as the patient with an organ to be operated upon ["Baby Joe the patient" becomes Baby Joe as a "liver"]

The third phase is the transition from the bedside to the operating table – from Baby Joe and family, to Baby Joe as a patient, to Baby Joe as a liver. This should be an unemotional, realistic and life-determining period in the life of the baby.

I cannot allow myself to be distracted from the task. At some point, I have to cross the Rubicon, distance myself from the psychological and emotional engagement with the family and embrace the cold reality of the surgery that lies ahead. By doing so I enter a dynamic environment and space of stress, uncertainty, changing pathophysiology, and shifting goals. The baby has become an object with a congenital anomaly to correct. The minimum the neonate will ask from you is competent surgical care.

A successful outcome is not only determined by the pathology, but also by my technical and critical ability, experience, commitment and singularity of process. I have to develop a barrier and actively disengage from the emotional and psychological ties that have developed between the family and me, to concentrate totally on the task ahead, realizing that faulty judgment, technical errors or lack of concentration and tiredness can have detrimental consequences. So often I have reflected on my collective memories of clinical situations and realized that most of my surgical errors stemmed from misperception rather than from a lack of judgement or surgical skills.

I would say that 70% of important events during an operation relate to decisions taken and 30% to manual skill. Operating theatres often present the staff with high risk situations where the unexpected may emerge, requiring a rapid response. These two factors are the fulcrum around which success revolves. It so often happens that during the operation, unexpected conditions or unanticipated problems arise and one realizes that the initial diagnosis is different to what one was prepared for, requiring new decisions and a change in the planned approach. What prevails here is good judgement and sound decision-making, often relying on stored memories or intuitive decision-making of previous successful interventions. It is in these seconds that the voices of my mentors are loud and clear in my head, helping me to take the correct next step.

Dr David Heimbach, a surgeon from Seattle with whom I trained, left me with sound advice: "Do the right thing the first time"

and “take responsibility for your mistakes.” During a conference in Nairobi in 1994, Prof Pena was asked by a student about the most difficult operation he has ever done. His answer was “It was the one I had not prepared for.” Those infants who receive the correct surgery from the beginning do much better than those with unresolved or persistent problems that linger on for years to come, especially if faulty judgement led to the wrong surgery.

Potentially this is a very stressful space to be in, especially if you have had complications in the past that have led to an adverse outcome. These consequences can easily lead to distress, emotional exhaustion, de-personalization and a decreased sense of personal achievement – a dangerous situation. They keep on returning like dark shadows and can have a significant influence on our surgical ability and performance.

#### Phase Four: The aftermath and the future for baby and family

The fourth phase is the often the most challenging and is more difficult than the actual operation: if the surgery has proceeded as anticipated, positive and encouraging information can be given to the anxious parents. However, with a seriously ill or dying baby, we have to cross the Rubicon a second time when we meet the family again.

We understand our role in the treatment of diseases but experience great difficulty in making the life-threatening illness of a baby and his impending or actual death as bearable as possible for all concerned. We have limited professional skills in handling this and often turn away from the tragic reality and leave it to others to deal with the family. How is it emotionally possible to talk to parents about your unsuccessful attempts to help their newly born child or to tell them that the baby, which they have longed for, is going to be severely deformed, handicapped or may even die? This has been the most difficult and unresolved part in my whole career.

We are often asked questions post-operatively, some which we can answer, others we can prognosticate on based on our collective experience, and there are other questions which cannot be answered. These questions include: Will my baby survive? Can I stay with him/her all the time? Will he/she be deformed and scarred? Will more operations be needed? Will his/her growth and development be influenced? Will he/she be able to live a normal life? How long is he going to stay in hospital? Was I responsible for the anomaly? And finally, “what now doctor”?

We are ill-equipped to answer many of these questions.

## Aftermath

During my lifelong involvement with neonatal surgery, I have witnessed the consequences of the pathology and what my surgery could and could not do. Many children who initially may be perceived as successes, are burdened with increased restrictions in everyday life and at times with life-long disabilities, disfigurement, developmental and behavioural disorders, vision and hearing disabilities, infertility, secondary tumours and the disintegration of their families.

Furthermore, there are those situations where life-extending and sophisticated treatment methods are used to prolong life with little or any hope of a meaningful outcome. All of us will face this crucial issue in our professional lives and quality communication between the clinician and parents may ease the burden.

The psychological impact of diagnosis, living in the Paediatric Intensive Care Unit, becoming the parent of a critically ill baby, being traumatized by their infant's illness, coping and facing an uncertain future, will have long-term consequences on the family. We have all been aware of the depression, anxiety and attachment disorders amongst the mothers and fathers of our patients. This too remains part of us.

The only way to live with the memories of successes and failures, is to know that I have done my best when the infant was entrusted into my care in the moment of crisis. The successes may fade in our memories, but our failures are etched into our minds for eternity.

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# Perspectives readership responses to Perspectives in Infant Mental Health: Infants, families and refuge

By Maree Foley, Debbie Weatherston and Grace Whitney

As editors of *Perspectives* we are delighted to collaborate with Grace Whitney (PhD) to further highlight the needs of infants in Refuge. Grace Whitney, Ph.D., MPA, IMH-E (IV) is the Director of Early Childhood Initiatives at SchoolHouse Connection, USA. This column features a response from Grace, to the recently published article in *Perspectives* by Wendy Bunston: How Refuge provides refuge to Infants: Exploring how 'refuge' is provided to infants entering crisis accommodation with their mothers after fleeing family violence (*Perspectives in Infant Mental Health*, Vol.26. No. 4, Fall, 2018).

"Thank you so much for sharing this! The article on Refuge again points out that systems designed to provide refuge are "adult-centric" and rarely, if at all, take the needs of infants and young children into account, from the trauma informed response used to nutrition to health care and on and on. IMH professionals everywhere must put on their to-do list the 'childproofing' of every single system there is in our worlds...in our universe! If an IMH lens can be used to review every single policy, practice, educational effort, resource allocation, and more, we will be leaving behind a better network of support for infants and parents as we move forward. Babies matter. Their meaningful relationships that help them feel safe matter. I will be sharing this piece with others for sure" (Grace Whitney).

Contributing further to the conversation about infants and refuge, Grace offered the following links to resources to share with the *Perspectives* readership. The first link takes you to the *Early Childhood Self-Assessment Tool for Family Shelters* – A guide to support the safe and healthy development of young children in shelters,

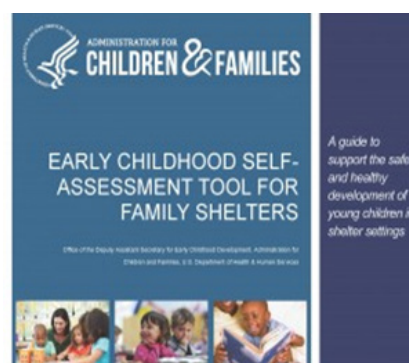
published by the Administration for Children and Families, USA (<https://www.acf.hhs.gov/ecd/interagency-projects/ece-services-for-homeless-children/self-assessment-tool-family-shelters>).

The second link takes you to a recent publication: *Childproofing Checklist for Housing and Homeless Service Providers* (2018), published by the SchoolHouse Connection (USA) (<https://www.schoolhouseconnection.org/childproofing-checklist-for-housing-and-homeless-service-providers/>). If you follow this link, you can download the *Childproofing Checklist for Housing and Homeless Service Providers* "TEN S's for SAFETY".

*The SchoolHouse Connection* is based in the USA. It is a:

... national non-profit organization working to overcome homelessness through education. We provide strategic advocacy and technical assistance in partnership with early childhood programs, schools, institutions of higher education, service providers, families, and youth. We believe education is the only permanent solution to homelessness. Our vision is that children and youth experiencing homelessness have full access to quality learning, birth through higher education, so they will never be homeless as adults, and the next generation will never be homeless. (<https://www.schoolhouseconnection.org/about/about-schoolhouse-connection/>)

Thank you Grace for the feedback and for sharing these very useful resources.



# Featured Report Column on Babies and Homelessness

By Maree Foley

This is a new column. It features publicly available reports from any international organization, country or state that addresses areas of relevance to the mental health of infants with their families.

For this issue, continuing with the theme of infants and homelessness, two links are provided that further address this issue.

The first link takes you to the full report: *All Babies Count report, An unstable start: Spotlight on homelessness (2015)*. This report is authored by Sally Hogg, Alice Haynes, Tessa Baradon and Chris Cuthbert. It was published by NSPCC All Babies Count Spotlight in partnership with the Anna Freud Centre, London, UK.

Link: <http://www.nspcc.org.uk/allbabiescount>

The second link takes you to the following slide set: *The impact of homelessness on babies and their families*. Learning resource for the Homeless Health network, QNI. NSPCC and the Anna Freud Centre UK. Link: [https://www.qni.org.uk/wp-content/uploads/2016/09/homelessness\\_babies\\_families.pdf](https://www.qni.org.uk/wp-content/uploads/2016/09/homelessness_babies_families.pdf)

This source is an e-learning slide pack published by the NSPCC. It was developed to directly support practitioners working with families with babies who are homeless. The content of the slides provides a summary of the full report: *All Babies Count report, An unstable start: Spotlight on homelessness*.

As editors, we welcome your suggestions of reports to feature in feature issues.



# WAIMH Office News: Read and browse past issues of Perspectives in Infant Mental Health

By Minna Sorsa, Tampere, Finland

*Perspectives in Infant Mental Health* has existed as *The Signal* since 1993. The journal Editors were Charley Zeanah (1993-2000), Paul Barrows (2001-2006), Miri Keren (2007-6/2012), Deborah Weatherston (7/2012-2018) and Maree Foley (2019-).

Past issues of WAIMH *Perspectives in Infant Mental Health* 2007-2018 are now available online at the WAIMH website.

Follow this link: <https://perspectives.waimh.org/perspectives-archive/>

You can search the full issues by year.

Past articles are also available online in text format, which you can share.

Link: <https://perspectives.waimh.org/>

The WAIMH articles can be viewed via searching special categories or you can search past articles.

You can choose to read the full issue eg by looking for an article by Miri Keren, when she visited Japan. Try to search by author name. You will find the text: "Personal

Reflections about Trauma and Play and an Invitation to Reflect".

<https://perspectives.waimh.org/2015/06/15/personal-reflections-trauma-play-invitation-reflect/>

The full article is visible beneath the text.

The full issue Vol 23, Issue 3 is also available in link under "PDF archive": [https://perspectives.waimh.org/wp-content/uploads/sites/9/2018/11/9th\\_July\\_issue3\\_2015\\_Perspectives\\_IMH.pdf](https://perspectives.waimh.org/wp-content/uploads/sites/9/2018/11/9th_July_issue3_2015_Perspectives_IMH.pdf)

We are constantly developing the Perspectives website, and we intend to publish all issues since 1993.

Vol. 21 No. 1 | Winter 2013

## Perspectives in Infant Mental Health

Professional Publication of the World Association for Infant Mental Health

### A Tribute to Daniel Stern – Mentor, Colleague and Friend

By J. Kevin Nugent, Director, the Brazelton Institute, Boston Children's Hospital and Harvard Medical School, USA

Dr. Daniel N. Stern died in Geneva, Switzerland on November 12, 2012. He leaves his wife, Nadia, who collaborated with him on much of his research, his two sons, Michael and Adrien; three daughters, Maria, Kaia and Alice Stern; a sister, Ronnie Chalif; and 12 grandchildren. To them we extend our deepest sympathy.



Everyone who knew Dan will remember his brilliance, his charm and his

research, he dedicated his time to the

Contents

This is a previously posted paper from our *Signal archive*: “The era of using video for observation and intervention in infant mental health”, by Nicole Guédénéy and Antoine Guédénéy. It was published in *The Signal*, 06/15/2010.

By Antoine Guédénéy, MD

Nicole Guédénéy, MD

France

The use of photography and cinema then video in developmental studies and in interventions began long ago, with the seminal work of Rene Spitz, then with John Bowlby's and James and Joyce Robertson's famous films, e.g. John and with several others. These have had an enormous influence on our understanding of infant mental health and in its recognition as a field. This paper presents a short history of the work of the early “cinema” pioneers, then briefly reviews how video has provided a focus on the importance of infant development and early interactions and concludes with how preventive work with infants and families has greatly benefited from the use of home videos.

## A bit of history

Arguably, the beginning of using movies in infant development studies can be traced with Rene Spitz's films in 1943. Spitz showed the full extent of the distress of infants who were separated from their mothers in his famous film, *Grief, a Peril in Infancy*. Young mothers had their babies when in jail and were separated from them daily when the infants, 6 to 8 months old, were moved to the prison day care facility. Some of the infants showed high distress, named ‘Anaclitic Depression’ by Spitz as the developing attachment relationship was observed to be at risk, even though he stated this was not depression in the full sense of the term (Spitz, 1945, 1946, 1947). The infants who experienced more extended separation from their mothers, showed a more troublesome and less reversible picture, labelled by Spitz as ‘Hospitalism’. At this point in time, most of the work on early development by psychoanalysts was retrospective and hypothetical. Spitz brought to the community the grim picture of what brisk and unprepared separation could do to the parent infant relationship. As Robert Karen points out (Karen, 1994), this was not well accepted or easily acknowledged

# The era of using video for observation and intervention in infant mental health

(Repost from *Signal* Vol. 18, No 2, 1-4)

when Spitz showed the film to the psychoanalytic community in New York. A colleague reportedly asked him, “Why did you do that to us?”

Another major step in the use of film for the purpose of observation was taken when James and Joyce Robertson followed an 18 month old boy during an 8 day separation from his parents for which the child was unprepared. In looking at the images of John at the nursery, day after day, the Robertsons and colleague, John Bowlby, were struck by the amount of distress displayed by this 18 months old boy. His distress could have been easily overlooked if he had not been filmed, day after day, at the same time. This, of course, led to a great deal of controversy. Today, this film is still hard to look at, and represents a formidable teaching tool. Other films, taken by the Robertsons for the purpose of infant observation and study, added to the evidence regarding the impact of extended separation and coping capacities of infants and young children. These films included *Lucy*, *Thomas*, *Kate*, and *Lucy, in A Two Year Old Goes to Hospital* (Robertson & Bowlby, 1952; Robertson & Robertson, 1969). In the fifties, some other clinicians used films as a demonstration of the existence of specific syndromes linked with relationship disorders. The pictures and movies from Monica, Engel & Reischman (1979) vividly illustrated the case of an 18 month old girl born with an oesophageal fistula and showing clear signs of depression/withdrawal. Of course many other contributions existed as well during this pioneer period, but let us quote only the films made by Myriam David and Genevieve Appell in orphanages and institutions in Post War France, as they had a great impact on the changes in these institutions (David & Appell, 1964; Dugravier & Guédénéy, 2006 for a review). In the same vein, films in the Loczy Pikler Budapest institute in Loczy, Hungary have been very influential in designing better care for orphans (Tardos & David, 1961).

The era of discoveries of competencies and vulnerabilities of the infant: lessons from the Great Baby Watchers (T. Berry Brazelton, Beatrice Beebe, Tiffany Field, Daniel Stern and Ed Tronick)

This period starts with the seminal work of T. Berry Brazelton, describing the ‘*Four stages of interaction*’ seen at a micro-analytic level (Brazelton, Koslovski & Main, 1974). The baby takes the lead, rather than the caregiver. This becomes obvious from the frame-to-frame analysis of the video. Then the ‘*Still Face paradigm*’ (Cohn & Tronick, 1983; Field, 1984) shows how 2 month olds are trapped into the face-to-face interaction and shows their high sensitivity to violations of rhythm within the dyad. Murray & Trevarthen (1985) confirm this sensitivity, using the de synchronization procedure, in which baby and mother interact through a video channel, in which sound and image are subtly de synchronized. This demonstrates how sensitive the 2-month-old infant is to violations of expectations within the interaction: a single de-synchronisation of a tenth of a second has exactly the same effect as a still face procedure (See Rochat, *The Infant's World*, 2001 for a review).

## Why look at oneself interacting with an infant?

This situation may help us learn how interaction truly develops: Brazelton, Tronick, Beebe and Stern, looking at who does what and when, have helped us understand how the interaction truly develops, as opposed to reconstructive speculation. Looking at oneself interacting with an infant will help see the ‘objective self’ of the observer, seen from the outside and integrate it within the ‘subjective self’, seen from within (Rochat, 2001). Several manualized programs are available now, which show us how autovideo has a huge impact on helping the parents realize to which extent the infant is sensitive to relationships. It helps moving from an expert's point of view to a ‘let's see together what we have here’ perspective, increasing the working alliance when

noticing the parents' own expertise.

## The 'Attachmentists' and the video: the Strange Situation, the disorganization of attachment

Video allows the scoring and training of the Strange Situation with infants and toddlers with different attachment systems (Ainsworth, Marvin, Crittenden, Cassidy, see the *Handbook of Attachment*, 2008, for a review and references) and at different ages. Separation contextualizes the situation with a middle level of stress. Video helps identify the often subtle and brief signs of infant disorganization, as well as disorganizing behaviours in parents (Lyons-Ruth, 2005). Frightening/frightened behaviors or abdicating behaviors are some of the variations leading to an infant's disorganization of attachment. These behaviors may be subtle, occurring very quickly. One has to be particularly attentive to what happens or not when attachment is activated. The key point is that video is most interesting when the attachment system of the infant is stimulated, through fear, separation, anxiety, and distress of any kind, hunger, sleepiness or pain. Video can capture what takes place - secure base behaviour or its absence or brief events described as disorganized behaviours. The main idea here is the use of contextualized specific situations during which attachment or exploration behaviors are activated, be it free, cooperative play, face to face or still face, separation/reunion, nappy changes, feeding. Related projective assessment techniques such as the *Mc Arthur Story Stem Battery* (Bretherton & al, 1990) do use video, for the procedure as well as for training and reliability.

Some Attachment based interventions use video and the strange situation as a core tool:

- *The 'Circle of Security' COS*: Marvin (Marvin & al, 2002) has established a system of assessment of secure base behavior that can be used in group or in individual settings, with parents' reactions to the strange situation of their child.
- Slade (Slade, 2008) and Karlen Lyons-Ruth (2005): Nurse/IMH joint programs for high risk mothers, use auto video in interactional guidance, to increase self reflective function in mothers.
- Juffer & Bakermans preventive use of auto video with adopted infants shows great effect size, compared to usual guidance. Juffer, Bakermans & van IJzendoorn: the *Video Feedback*

## *Intervention for Promoting Positive Parenting (VIPP, 2005, 2007)*

- *STEEP*: Martha Erickson's and Egeland's program, 'Seeing is Believing,' is one of the most effective programs for prevention and intervention, using video with families. (Egeland & Erickson, 2004).
- *CAPDP*, the first French prevention study for high-risk mothers, uses video extensively for increasing a mother's sensitivity and mentalization and reducing parental disorganizing behaviors.

All these models use auto video guidance, a major tool for intervention & prevention, since video is such a strong incentive for maternal/parental mentalization: 'What do you think the baby is feeling now? Why? What are you feeling when you are doing this?'

A major advantage of video is to help look at organizing and disorganizing behaviors in parents: *AMBIANCE*: is a scale for assessing parental disorganizing behaviours, through the assessment of emotional communication (Lyons-Ruth et al, 2005), through clips of strange situation and play.

## Names and models in interventions using video

### Some of the pioneers

Selma Fraiberg (1980) used film to carefully assess the capacities and risks of infants and parents referred for infant mental health home visiting services, during consultation with parents and to study interactions and early relationship development during supervision and consultation to understand the risks and enhance the capacities of parents and very young children.

Susan Mc Donough (Mc Donough, 1993) has long used video with hard to reach families as a major tool for making interactive guidance effective. Susan Mc Donough was one of the first to have designed video use with hard to reach families. She gave us some major cues for this work: stick to the goals of the family, closely monitor working alliance, and keep on working on the positive aspects.

Maria Arts: Marte Meo (2008) Beatrice Beebe, in parent infant therapy (Beebe & Stern, 1977) Daniel Stern: His work with Bertrand Cramer was essential to understand ways through which parent-infant therapy works. The comparison of psychodynamic vs. CBT showed no

major differences, but video was key to understanding changes in therapy (Stern, 1995).

Serge's Lebovici's use of empathy and action within the parent infant relationship was remarkable in his recorded therapeutic consultations (Lebovici, 1983).

Elisabeth Fivaz-Depursing and Antoinette Corboz-Varnery (The Primary Triangle, 2004): based on systemic principles, their work on Triadic interactions is a major contribution to the understanding of early mental development. It is based on closely organized video clips with both parents, leading to an assessment system of the triangulation within the family.

John Byng-Hall has designed an attachment-based family therapy with the use of video to supervise and train therapists (Byng-Hall, 1995)

George Downing has worked with Ed Tronick, Beatrice Beebe and Bob Marvin. He has gathered a very large experience with video in different settings, with infants and mothers in patient unit in Germany, and in parent infant consultation in France, as well as with adolescents; he proposes his frame of analysis for videos with parents and infants, and guidelines to make videos and to watch them with families (Downing under press ): Downing suggests to look carefully at these dimensions prior to watch the videos with parents:

### Downing's frame of analysis of videos clips:

- Connection: contact, affect attunement, contingency
- Collaboration: how is shared activity organized?
- Boundaries: limit - setting
- Negotiation: mostly verbal
- Autonomy: how are separation autonomy and problem solving played
- Organization of time: Rhythm and temporality, frame and continuity
- Organization of time: Tempo, fast or slow
- Discourse; what is said and how

Finally, video has become a major tool for training/ supervision and for seeing what is going on in such a setting, with the miniaturisation of cameras and the diminution of costs.

## Lessons from the Great Baby Watchers

Video has permitted us to gain insight into the way parent infant interaction develops. Through this tool we have learned from the Great Baby Watchers: Beebe, Stern, Tronick, and Brazelton, among others. To summarize:

- Look at the frame by frame, micro analytic interaction
- In secure dyads, even when things are 'As Good as they Get,' the rate of misattunement may reach 50%
- Being securely attached is working through mismatches, not avoiding mismatches
- For pairs with too frequent or intense mismatches, frustration or fear of loss may lead to give up search for attunement
- Video helps focusing on the baby and on the relationship and helps the parent take the baby's perspective
- Show the big difference between what we as parents believe we do and what we effectively do, particularly when stressed
- Rhythmic coupling at 4 mo (turn taking, joining, yielding and tracking) predicts attachment classification at 12
- In mild to major disturbances of relationship, defensive maneuvers in the child get built up quickly (i.e. by 9 months of age)
- Attachment behavior is resistant to change, but there is always room for change So need for focused preventive action on traumatized dyads

## Using video with early diagnosis of autism

The seminal work of Massie opened the way through analysis of family videos of autistic children. Now that video is much more easily available, we can often get family films and see them with parents. The goal is to find the early specific signs of autism, see the different modes of onset and discuss the diagnosis with parents (USA: Massie 1975, Massie & Rosenthal, 1984; Osterling & Dawson, 1994 France: Malvy, Adrien, Brauner & Wendland; Italy: Bernabei & Camaioni, 1998; Maestro 1998 (see Wendland & al for a review and references).

## Using video in assessment

Video is now playing a key role in the clinical assessment of infants and parents. Several situations or assessment scales rely mainly on video clips of infants and parents in several settings:

Use of several clips from strange situation, play, change, clean-up in the assessment of children in foster care *The Alarm Distress Baby Scale* (ADBB Guedeny & Fermanian, 2001): using a pediatric examination a 'Set Situation' to assess withdrawal behavior in infants Feldman's Classification of Infant Behavior: using a feeding situation to assess parent infant interaction Feldman CIB, (Feldman, 2007). *Ambiance*: Lyons Ruth & al (2005): caregiver disorganizing behaviors in the strange situation Marvin's use of the strange situation and Circle of Security© (2002).

## Conclusion

Video has become a major tool for psychotherapeutic intervention and prevention, as it allows us to catch brief and meaningful events that can be reviewed with the parents. It helps to focus on the young child's reactions and interactions within the context of developing relationships. It is a key tool for training and supervision. Its strength is to highlight positive aspects that parents may be unaware of in the middle of difficult relationships. However, its use must be closely framed within the therapeutic relationship with the family. It should be avoided when parents are in a conflict about the care of children with legal implications.

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# WAIMH Affiliates News

By

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## Growing Infant Mental Health in the world-a challenge for us all.

At the Rome Affiliate Council meeting in May 2018, affiliate presidents were invited to contribute to the work of the Affiliate Council by participating in one of two working groups.

One of these working groups will be progressing the development of a set of guidelines for local infant mental health groups to become "WAIMH Affiliates".

Some of the most populous areas of the world such as China, India, and many parts of Africa, South America and Asia are yet to form professional organisations under an infant mental health umbrella specifically for the advancement of the social and emotional needs of infants. In some contexts, infant survival is such a pressing concern that their social and emotional needs may seem a secondary issue. However, the capacity of caregivers to protect and provide for their children, are not just about the physical health of the caregiver and the baby but just as importantly, about their mental health. Furthermore, infant mental health activities can be embedded in other activities, such as those designed to enhance child development, support for women, or local health and housing initiatives.

In many of these contexts, there may be no infant mental health focused professional group because there is limited awareness of infant mental health as an important priority for the future wellbeing of children. Conditions may be difficult for local professionals who may be growing their own awareness and understanding of these important developmental opportunities to strengthen communities, support families, protect caregivers and their infants and engage communities in culturally relevant research. Even in more



developed contexts, there may not be a local network or group specific to infant mental health.

WAIMH Affiliate council can connect with and encourage local groups with a developing interest and professional involvement in infant mental health to build a formal connection to WAIMH. The benefits of being part of an international scientific and professional association focused on the advancement of Infant mental health around the world include strengthening local advocacy efforts, connecting with other colleagues for support with this difficult work, and sharing the learning that comes from these experiences.

At present, members of this working group include Dawn Cannon (AIMH, UK) and Nicole Letourneau (Alberta, Canada) as well as Anna Huber (Affiliate Council Chair) and Jane Barlow (Affiliate Council Representative). We would highly value input from other members living and working in parts of the world where the field of infant mental health is less developed, who can add valuable

perspectives to these guidelines as we develop them. Such input can also inform the work of the WAIMH board by strengthening the diversity of perspectives within our international infant mental health association.

Contact Anna or Jane if you have ideas to share.

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