

Perspectives in Infant Mental Health

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From the WAIMH Board President: Kai von Klitzing Should We Diagnose Babies?

Some Notes on the Launch of the New Zero to Five Classification System



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Recently the US organization Zero to Three (ZTT) launched the new classification of mental health and developmental disorders of infancy and early childhood (DC:0-5). In contrast to the previous DC 0-3 R, this system includes also preschool children. The diagnostic categories have been revised according to new clinical knowledge and research findings. In addition, "relationship disorders" have been included as a distinct category on axis I, alongside describing the relational context of disorders on the separate

axis II. The manual is the result of a long and intensive collaborative effort by the Diagnostic Classification Revision Task Force chaired by Charles H. Zeanah. The aim was to carefully describe and categorize descriptive syndromes and symptoms involving distress and the impairment of functioning over time (axis I), and to integrate these descriptions into the contexts of relationships (axis II), physical health (axis III), psychosocial stressors (axis IV), and development (axis V).

There is still controversy within the international interdisciplinary infant mental health field (represented by more than 50 WAIMH affiliates) over



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whether the categorization of the mental health problems of infants by psychiatric diagnoses is adequate. Some colleagues state that the mental organization in early childhood is still so fluid that it is inappropriate to use relatively rigid categories to describe individual characteristics. Many clinicians and developmental researchers argue that sleep or feeding problems reported by parents in the consulting room, for example, are more an expression of troubled relationships and less individual characteristics of the infant. Last, but not least, some draw our attention to the fact that psychiatric diagnoses are associated with considerable stigma in nearly all societies. So should we put the development of the youngest at risk by burdening them with diagnoses such as anxiety disorder, depression or autism spectrum disorder?

On the other hand, babies are not angels. Of course, the younger the human being, the more knowledge of the relational context is necessary to understand his/her behavior and emotions. But nevertheless, infants do contribute actively to relationships and are not merely passive "victims" of detrimental environments. Instead of avoiding any kind of psychiatric terminology it might be more helpful to develop developmentally sensitive diagnoses which link psychopathological descriptions to the individual's developmental situation. In the middle of the last century René Spitz drew our attention to the fact that the diagnosis "depression" describes a condition which can impair individuals over their whole life cycle. His notion of anaclitic depression – a severe syndrome causing tremendous suffering during the first and second year of life – initially met resistance and skepticism, but changed practices in children's hospitals and nurseries dramatically for the better. Developmentally sensitive diagnoses can help the inclusion of early childhood into our concepts of mental health; adequate diagnostic categories allow infants to be included in necessary clinical studies; and in most countries, a diagnosis is a precondition for access to mental health services.

But there are still reasons for concern. Let me give the example of Attention Deficit Hyperactivity Disorder (ADHD). This is a relatively new diagnostic entity which describes the difficulties of some individuals in focusing their attention on socially important tasks, regulating their impulsivity and suppressing the urge to move when it is not appropriate (in school or at work). Although this diagnostic

category is based on systematic clinical observation and neurophysiological research, it is still a fact that its origins lie in the discovery of a pharmaceutical drug that improves attention and behavioral inhibition. So first there was a drug, and then a diagnosis was created to fit the drug. We currently see a strong tendency towards expanding this diagnosis both into adulthood and into younger ages. DC 0-5 proposes two age-specific categories which reflect this tendency: Attention Deficit Hyperactivity Disorder (starting from age 36 months) and Overactivity Disorder of Toddlerhood (age 24 to 36 months). When reading the diagnostic algorithms, it soon becomes clear that these diagnostic categories describe quantitative rather than qualitative deviations from the norms: "symptoms must be excessive when compared with developmentally and culturally norms" (p. 26), and "cultural expectations are critically important in defining behavioral expectations and impairment" (p. 33). All the behavioral phenomena described as diagnostic criteria are related to social and cultural expectations. Put bluntly, the fact that the prevalence rate of the disorder has increased to 6% in school children does not tell us whether this is due to an increase in disordered children, or whether clinicians have become more alert to the symptoms, or whether social norms have changed over time with less tolerance towards children's needs for movement and impulse expression. I wonder what the prevalence of preschool ADHD and toddlerhood overactivity will be as soon as infant mental health clinicians start to use the diagnosis to describe young children's behavior. In a study by our research group, mothers reported significantly more hyperactive behavior of their children when they were in preschool age than two years later when they were in kindergarten or young school age, a result that showed that parents tend to overestimate their children's capacities of motor- and impulse regulation in the earlier years (Klein et al. 2015).

The launch of the new DC 0-5 system happens at a time when the validity of categorical psychiatric diagnoses has been questioned by developmental psychopathology researchers. For example, Forbes et al. (2016) conclude from epidemiological studies that half of the individuals who meet the criteria for one mental disorder would also meet the criteria for a second at the same time, half of those who meet criteria for two disorders will meet criteria for a third, and so on. "Comorbidity" does not seem to be the exception, but the rule. This highlights the general lack of

distinctive validity of psychiatric diagnostic categories. The authors conclude “that our diagnostic systems are incompatible with the nature of psychopathology” (p. 972). This seems especially true for early childhood. If a child is diagnosed with a comorbid pattern of, let’s say, ADHD and anxiety and/or depression, it does not mean that the poor child has two or three separate disorders. It is more likely that his/her behavioral problems are caused by his/her anxiety. Hyperactivity might be the expression of a hypomanic defense against unbearable depressive feelings. Therefore it does not make sense to categorize this typical pattern as a co-occurrence of several distinct disorders. Beauchaine and Cicchetti (2016) argue that high rates of homotypic comorbidity, and well-characterized heterotypic progression along the internalizing and externalizing spectra, suggest that at least some DSM disorders assumed to be distinct are in fact alternative developmental manifestations with common etiologies (p. 892). The authors state that the general pattern whereby vulnerabilities interact with environmental adversities to produce expanding and changing symptom expression across development, is observed in almost all multifactorially inherited disorders. “Early life impulsivity may never develop into more severe psychopathology in protective environments characterized by secure attachment relationships, effective parenting, neighborhood cohesion, and positive peer groups” (Beauchaine & Cicchetti 2016, p. 892).

The multifactorial origin of mental disorders and the heterotypic course of symptoms might be better described by patterns of dimensional coordinates than by comorbid diagnoses. The Research Domain Criteria (RDoC) initiative has specified five major domains of behavior (negative valence, positive valence, cognitive, social, and arousal/regulatory), which are assumed to interact with one another to affect mental health development and to cause psychopathology. Even if we cannot be sure that these domain definitions will hold for enough empirical evidence in the long run, there is every indication that this is a promising approach to defining dimensions of behavior and social interaction that enable a better grasp of biobehavioral vulnerabilities that can, under certain social and relational conditions, lead to psychopathology. This new dimensional thinking in developmental psychopathology can be the basis for “future research to evaluate complex Biology x Environment interactions in the development of

psychopathology, its comorbidities, and its continuities” (Beauchaine and Cicchetti, 2016, p. 893).

WAIMH Perspectives offers a forum for critical discussion, including views advocating both the dimensional and the categorical approach. This means that WAIMH should not uncritically promote one diagnostic system but should support a free and open debate about how best to describe mental problems in childhood. No matter whether one chooses a categorical or a dimensional approach, the diagnostic description should always include individual and relational formulations. This holds for the entire life cycle, but it is especially true in early childhood. In addition, WAIMH should push for an intensification of our efforts to assess and treat mental health problems as early as possible in life, because we know that many psychopathological phenomena have their origin in the early years. Currently there seems to be a split: to establish infant mental health services in the medical system requires diagnoses that are acknowledged not just by the community of clinicians but also by the health insurance companies. Diagnostic categories are also essential for epidemiological studies which build on commonly accepted diagnoses. On the other hand, in the current state of psychiatry these diagnoses are merely descriptive and represent neither distinct etiological entities nor specific developmental pathways. Therefore, it seems potentially problematic to base urgently needed research efforts entirely on these categories. In the long run, this kind of split between clinical and research approaches might weaken the field.

In summary, WAIMH must advocate for building mental health care systems for the youngest in our communities, because most life cycle mental health problems have originated in early childhood. Untreated health problems in these early years create burdens for the individual life cycle as well as for society. WAIMH will therefore continue to provide a forum for interdisciplinary exchange between clinicians and researchers in order to support progress in our vital field.

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Farewell to a Respected Colleague, Louise Emanuel

Contributed by

Juliet Hopkins and Jane Barlow

On behalf of the Tavistock and AIMH UK

It is with very great sadness that we learned about the death of Louise Emanuel, child and adolescent psychotherapist, following a very sudden and traumatic illness.

Trained at Tavistock in London, a respected and beloved colleague of international repute, Louise had a gift for presenting psychoanalytic ideas clearly and helpfully. She had a formidable energy and her work brought acclaim to the Tavistock. Her capacity to make sense of behaviour helped relieve young children of their anxieties and find more adaptive modes of coping, thereby supporting emotional growth in the entire family.

In 2000 she took over the management of the Tavistock Master's degree course in Parent Infant Psychotherapy (PIP) and ran this successfully for 16 years. Many of the people who did the course went on to set up PIP clinical services round the country. In addition, she launched a bi-annual short course in PIP, which was enthusiastically supported by many therapists from both UK and abroad.

In her capacity as a psychotherapist, Louise was able to make swift connections



with children and she wrote about the importance of this in a chapter entitled *What Can the Matter Be?* in the book she co-edited with Elizabeth Bradley in 2008, [A Slow Unfolding at Double Speed](#). "For therapeutic interventions to be effective," she said, "the therapist had to combine patience with close attention to the moment

In recent years, she used her therapeutic skills in work with a South African charity, [Siya Phula Phula](#) ("We listen"), to help households sometimes headed by children as young as 12 and trained mental health workers to support them. Her overall inspiring contribution at home and abroad was immense, and she will be greatly

missed by all of us.

Louise was an active member of AIMH UK who will be dearly missed. During her last summer she was able to display the full range of her talents at the 2016 Prague meeting of WAIMH where she was a main speaker in many presentations and conducted a clinical supervision masterclass. One of her aims was to raise the level of psychoanalytic thinking in WAIMH.

This year, the [Association for Infant Mental Health UK](#) will award a Louise Emanuel prize for a significant contribution to the field of infant mental health.



A WAIMH Profile: Campbell Paul, President-Elect of the WAIMH Board of Directors

Campbell Paul, President-Elect of the WAIMH Board of Directors, is a consultant infant psychiatrist at the Royal Children's Hospital and the Royal Women's Hospital in Melbourne, Australia. At the invitation of the offices of *Perspectives in Infant Mental Health*, Campbell shares some of his interests in and entry into the field of infant mental health and acknowledges the importance of WAIMH in bringing together so many enthusiastic, talented clinicians and researchers, each committed to the welfare of infants and their parents. In his own words:

It's always said that infant mental health conferences are ones where there is remarkable collegiality and mutual support. I guess, when you consider who are our founders and mentors, that's not surprising. Maree Foley in an earlier edition of *Perspectives* referred to the inimitable and inspirational Dan Stern who taught us so much about babies' capacities, passions and their relationships.

Watching the way that a sick or premature baby can hold on to the hand of her father who is struggling with unexpected trauma and grief in the hospital context, inspires me in my day to day activities.

The early years of my professional career were in psychiatry in Edinburgh, and then in child and adolescent psychiatry back here in Melbourne, Australia. My interest in psychiatry was intertwined with paediatrics, working with children, at my alma mater, the Royal Children's Hospital Melbourne. The Children's has a long history of close collaboration between mental health and paediatrics and child health. Indeed, one of my key mentors, Dr. Ann Morgan, trained as a paediatrician in the UK, Ireland and the US, and then joined the Psychiatry Department at the Children's Hospital where she personified the importance of seeing babies as persons in their own right, with their own problems which require a personal therapeutic response. This perspective, the baby as the subject of our intervention within the context of the family, has been the essence of the fabric of my work since working with Dr. Morgan. As with many Australians, out of desire and necessity, I've been privileged to visit many centres of excellence in infant mental health around the world. I was really inspired early on by being able to work with Lynne Murray and her team at the Winnicott Centre in Cambridge, with Dilys Daws and Juliet Hopkins in London, with Serge Lebovici and Antoine Guedeney

in Paris and with Mary Sue Moore and Janet Dean in Boulder Colorado, along with so many other colleagues after that. What a wonderful beginning to a career with infants.

My clinical and research focus has been very much the engagement of very sick infants and their families, working alongside nurses, doctors and other health professionals within and outside the walls of the hospital. I'm always amazed at the capacity of very sick babies to reach out to their parents and for troubled parents to respond to their ill babies, when supported to do so. I believe we need to continue to develop our understanding of effective infant-parent psychotherapy; to explore the inner world of the stressed baby and the stressed baby-parent relationship, and share this with them. I say "with them" because I believe the baby has a crucial role to play in this. We've also been able to set up some programs to support mental health clinicians caring for parents with severe mental illness who have a baby. Those working in perinatal and in infant mental health certainly do need to work closely together.

The Infant Mental Health group of which I am a part at the Children's Hospital is an interdisciplinary group providing an infant mental health clinical response within a busy and complex paediatric hospital, undertaking a number of research projects, especially with sick infants and their families and also engaged in postgraduate university training. Brigid Jordan, a former WAIMH board member, has undertaken and fostered much research within the paediatric and infant mental health context. Megan Chapman, clinical child psychologist, is researching the impact on parental reflective capacity of having a sick baby and how we may enable parents to keep the mind of their baby in mind, even in the context of intense medical trauma.

Inspired by Prof Kevin Nugent in Boston, Dr Susan Nicolson and I now have at the Royal Women's Hospital the Australian Training Centre for the Newborn Behavioural Observation (NBO). Prof Louise Newman,



who was a plenary speaker at our Prague Congress, leads a team of clinical researchers at the Women's Hospital.

My first WAIMH Congress was in Lugano in 1990. Since then I've been to each WAIMH Congress, including of course the one held in Melbourne in 2000. At each, I have been re-inspired and reinvigorated by the enthusiastic generosity of so many infant mental health researchers and clinicians: WAIMH and the congresses provide such a creative and nutritive melting pot of people and ideas which sustains us in our work. There are huge challenges ahead for us and for the infants and families with whom we work. For example it is difficult to conceptualise the terror, the trauma, and the dehumanisation which thousands of infants and families experience as refugees in the Middle East and other parts of the world. How can we adapt the fine-tuned and sophisticated methodologies of infant-parent psychotherapy to support babies and parents in the middle of unimaginable despair? But, I know from the work of Miri Keren, Alicia Lieberman Charley Zeanah and so many others that there are ways of reaching and restoring hope for many really troubled infants and their families.

I look forward to seeing you all in Rome in May 2018 for another wonderful WAIMH Congress where we will try to address some of the huge problems confronting the world of infants and families whether on a small or large scale.

Why do we need to specifically address the Rights of Infants when we already have the Children's Rights Declaration?

By Miri Keren and Maree Foley

After having finalized our WAIMH Infant's Rights Position Paper and presented it in Prague at our last World congress, we had the opportunity on June 8th, 2017, to appear at the *Committee on the Rights of the Child (CRC)* meeting in Geneva. The aim of the meeting was to present WAIMH's perspective on why we need to specifically address the Infant's Rights.

On behalf of WAIMH we proposed to the CRC that: The issue of infant mental health be included in the agenda of the CRC's discussions and implementation efforts.

This is the summary of the main points we made, and no less important, the discussion that took place with the CRC 11 members (out of 18) who were present.

Background

The Convention of the Rights of the Child implicitly takes account of the profound need of infants to grow up in the context of safe relationships and in mentally healthy living conditions. The CRC has taken up many of the issues addressed in its 2005 general comment No. 7 on "Implementing Child Rights in Early Childhood". Nevertheless, infancy is such a basic and decisive period for the child's development that it should also be made more explicit in the children's rights debate. To further elaborate, a WAIMH task force (Lyons-Ruth et al., in press) has written a paper: *The worldwide burden of infant mental and emotional disorder*. This paper outlines why it is imperative to focus on and address infant mental and emotional health.

The worldwide burden of infant mental and emotional disorder (Lyons-Ruth et al., in press).

This document aims to create new priorities for health policy makers by highlighting:

- The concept of mental disorders, and mental and social health *in infancy*, in particular (birth to age 3 years), within service delivery systems and social policy is frequently unrecognized.
- The costs associated with mental disorders, and mental and social health *in infancy*, in particular (birth to age 3 years), remain largely invisible.
- The features of social and mental health and disorders in infancy are different than in the later years. For example, the experiences of infants are not described separately in the current versions of the ICD-10 and the DSM-5. To address this gap, the Zero to Three Diagnostic Classification, DC 0-5, a manual for disorders of infancy and very young children was developed. It is used by infant mental health clinicians but remains largely unknown among most professionals and health policy makers.

Why are these issues a problem?

- Infancy as a developmental period is unique because the brain and behavior are in vulnerable states of development during the first three years of life. Because of this developmental vulnerability, every infant has the potential to thrive and equally every infant has the potential to have its developmental path significantly deviated in response to early trauma and deprivation.
- In times of worldwide human crises caused by wars, violence, and global forced displacements, very young children suffer from insecurity and threats which they cannot understand through words or verbal explanations. Infant and early childhood experts, and parents, see first-hand that this kind of early negative experience can lead to posttraumatic stress, anxiety

and depression in infants and young children.

- Empirical research has dramatically shown that such mental health challenges in early childhood can adversely affect ongoing physical and mental health throughout childhood, adolescence and adulthood.

Key points (Lyons-Ruth et al., in press)

- Adverse early experiences may be especially harmful if they occur in the first three years of life, during formative periods for brain development, leading to enduring consequences.
- Due to the infant's immaturity, the features of symptoms and disorders in infancy are somewhat different from those in the later years, requiring separate diagnostic descriptors.
- During infancy, stressors on caregivers have particularly immediate consequences for the infant's developing stress response systems and overall development, compared to later ages.
- Early dependence on caregivers requires different modes of mental health intervention that involve both the infant and the caregiver.
- Evidence-based intervention approaches have demonstrated success in improving outcomes for children and families.

Furthermore, the Nobel Laureate economist James Heckman (2006) analyzed rates of return relative to investments in human capital by age. He showed that:

1. Gains can be realized by investing in children during the early years of life; and
2. Opportunities can pay large dividends in future productivity, equity and social justice.



Priorities (Lyons-Ruth et al., in press)

- Priority on global education regarding the signs of disorder in infancy and toddlerhood.
- Priority on enhancing the availability of treatment for infants and their caregivers.
- Priority on developing reliable information regarding infant and toddler mental health in developing and war-torn countries.

WAIMH position paper on the Rights of Infants

The WAIMH position paper on the Rights of Infants is a document that has been composed by the WAIMH Board of directors in a lengthy process of back and forth feedback from our WAIMH members. The final version was approved at the 2016 WAIMH World congress in Prague. The complete document can be viewed on the WAIMH website: www.waimh.org

This document is divided into two parts: the infant's basic rights, that should be endorsed everywhere, regardless of society and cultural norms; and the principles for health policy that are more sociocultural context - dependent.

I. Basic Principles of Infant Rights (Birth to three years of age)

1. The Infant by reason of his/her physical and mental immaturity and absolute dependence needs special safeguards and care, including appropriate legal protection.
2. Caregiving relationships that are sensitive and responsive to infant needs are critical to human development and thereby constitute a basic right of infancy. The Infant therefore has the right to have his/her most important primary caregiver relationships recognized and understood, with the continuity of attachment valued and protected - especially in circumstances of parental separation and loss. This implies giving attention to unique ways that infants express themselves and educating mothers, fathers, caregivers and professionals in their recognition of relationship-based attachment behaviors.
3. The Infant is to be considered as a vital member of his/her family, registered as a citizen, and having the right for identity from the moment of birth. Moreover, the infant's status of a person is to include equal value for life regardless of gender or any individual characteristics such as those of disability.
4. The Infant has the right to be given nurturing that includes love, physical and emotional safety, adequate nutrition and sleep, in order to promote normal development.

5. The Infant has the right to be protected from neglect, physical, sexual and emotional abuse, including infant trafficking.
6. The Infant has the right to have access to professional help whenever exposed directly or indirectly to traumatic events.
7. Infants with life-limiting conditions need access to palliative services, based on the same standards that stand in the society for older children.

II. Social and Health Policy Areas to be informed by these Principles:

1. Policies that support adequate parental leave so that parents can provide optimal care for their infants during the crucial early years of life.
2. Policies that minimize changes in caregiver during the early years of development.
3. Policies that promote the provision of informational support to parents regarding the developmental needs of their infants and young children.
4. Policies that recognize the importance of facilitating emotional support for mothers, fathers, and caregivers, as an important component of fostering the optimal development and well-being of the infant.
5. Policies that promote access to evaluation and treatment of risks to development by trained professionals who are culturally sensitive and knowledgeable about early development and emotional health.

6. Infants with life-limiting conditions need access to palliative services.
7. The provision of adequate circumstances, including time for mothers, fathers, caregivers to get to know their infants and become skilled in providing for their infant's care and comfort, throughout the support of their family and community. The right for parental leave, and its duration, should be valorized by the society, in a way that fits its contextual reality.
8. The provision of access to relevant early educational and psychological opportunities and programs that promote good-enough relationship experiences and thus, enhance cognitive and socio-emotional development.
9. Policies that ensure the provision of prompt access to effective mental health treatment for mothers, fathers, and caregivers that alleviates infants' suffering and insure optimal development for the child.
10. Policies that allocate resources for training and supervision for caregivers in babies' institutions, foster care professionals and foster parents, as well as resources for assessing and treating foster care infant's emotional and developmental status.

WAIMH's key message to the CRC

We propose that the issue of infant mental health be included in the agenda of the CRC's discussions and implementation efforts.

The meeting

Ms Renate Winter, the new Chairperson of the CRC opened the meeting while mentioning that the CRC has become aware very recently that they focused too much on education and care and hardly on mental health. She said that in light of this, our presentation comes at a very good time.

Miri Keren went through the 11 power point slides for 20 minutes, leaving half an hour for discussion (the meeting started 10 minutes late). The discussion was around nine questions asked by the CRC members and answers provided by Miri Keren, as follows:

Question : Under the list of the aims of WAIMH, you mentioned that the age range is "from Conception to the age of 3 years". Why "3 years"? Is there a specific rationale for that age? And is the IR position paper about the prenatal period as well?

Answer: The age range is based on the scientifically-grounded notion that the first three years are a unique period in the growth and development of the brain, especially regarding the structures linked with emotions. Regarding the prenatal period, WAIMH in its activities and congresses put a lot of emphasis on understanding the impact of various factors, such as stress and trauma, on the parents and the fetus. Still, in our position paper, we have deliberately decided to address only the postnatal period, as the rights of the fetus are a separate issue (and extremely controversial as we all know).

Question : It is more a comment than a question. I think it is indeed very important to focus on the mental health issue and to make it more explicit. Also, though comment 12 includes the importance of the child's non verbal cues to be read and understood, it probably needs to be more explicit.

Question : Would you consider a revision of the Comment 7 instead of creating a new Comment?

Answer: A revision would be very welcomed, and on behalf of WAIMH, I can assure you that we are keenly ready to invest time and effort at preparing scientific documents that would be needed for such revision process.

Question: What do you think about the right of the infant to be cared by his mother as the basis for judges to prefer sole custody rather than joint custody?

Answer: Regarding the relative importance of mothers versus fathers and its implication in custody dispute, this is a topic that is dealt with differently in various parts of the world. We know today, thanks to research data, that infants can securely attach to their fathers as well as to their mothers, and that fathers are able to be daily caregivers as well as mothers are, if given the opportunity. The view that infants first relate to their mother and only later are able to relate also to their father, does not fit this research data, so it has been very strongly grounded in the psychoanalytical view of human development. The clinical principle that guides us as clinicians is the right of the infant to experience continuity of his/her attachment relationships. Therefore, if the father has been involved in the daily care of his infant prior the separation, there is no reason why he should stop being so after the separation. On the other hand, joint custody can be at the infant's detriment if the parents are in a continuous state of high conflict. In sum, there is not a "one answer for all".

Question: In Africa, poverty, single parenthood and lack of qualified personal are so frequent that attention to mental health needs is not a priority. What can we do to change this in your opinion?

Answer: This is indeed a situation that evokes in us helplessness as it is so complex, in Africa as well as in many other countries, such as India for example. I think we can learn from some of our colleagues' experience at

WAIMH, such as Astrid Berg in South Africa, who has created a community-based network for lowering mother's depression (that is more often than not linked with adverse life conditions), and thus has impacted on the mother-infant relationship and the infant's well being.

Question: How does the infant's right to have a permanent caregiver can fit to the situation of institutional care?

Answer: It simply does not in most cases! Though there has been an effort to assign a "primary caregiver" to each baby in some places. This is the reason why many countries are in the process of abolishing baby homes, and prefer the option of foster families. Yet, it has been shown that most foster families need psychological accompaniment in order to be a real good-enough alternative to institutional care. Also, there is a trend in many countries (but not all) to establish a time limit for the period that an infant can spend at an institution. We may indeed need to be more explicit about this in our IR position paper.

Question: Why is the term "Best interests of the infant" does not appear in the IR position paper?

Answer: Actually, I may say that the whole document reflects what we define as the best interest of the infant! Still, it seems we need to be explicit about this important point...

Question: What do you think would be the Right of the infant to be with his mother in prison?

Answer: The infant's right is being close to its mother as long

as she has been an attachment figure before the imprisonment, and as long as the prison physical environment fits its developmental needs. In most cases, we would recommend the presence of a professional whose main task would be to ensure the baby is emotionally and physically safe with the mother and her other prison mates. I guess this is an additional point to address in our position paper!

Question: Would you define as the Best interest of the Infant to be primarily with the mother?

Answer: As I have said before, the role of fathers in the infant's development has been proved, therefore today, the definition of the best interest of the infant is to have both mother and father attachment figures.

Ms Winter, the Chairperson, closed the meeting, while thanking me as representative of WAIMH for bringing up important issues about infants and for presneting the WAIMH Infant Rights position paper. Three members (representatives from Russia, Japan, and Norway) came out with me to continue the discussion outside of the room. Following the meeting, Mr Benyam D. Mezmur, the Past Chair of the CRC, sent the following email to Kai, Maree and myself:

"Good afternoon

Thank you very much for the interesting presentation and interaction this afternoon with the members of the Committee!!

It is not a subject matter we claim to have much expertise on and the presentation and discussion afterwards was very useful.

As I said to Prof Miri, I don't remember the last time 4 members of the Committee followed a presenter out of the room to follow up on some things while the chair was saying let us please start:)

I hope we can make this not an event but a process, so that we benefit from your expertise as a Committee, in ensuring that the issues of infant mental health becomes well integrated in our working methods as we move forward. I will be happy to

exchange few ideas.

Thank you so much all for making this a reality.

Benyam"

As one can see, we still have quite a lot of work to achieve, but it was a real step of acknowledgment of the existence of mental health in the first years of life.

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- WAIMH Position Paper on the Rights of Infants. www.waimh.org

WAIMH Awards 2018

WAIMH offers four important awards in recognition of individuals from across the world who have made very important contributions to the infant mental health community in the course of their careers. Interdisciplinary by design, WAIMH invites nominations from the fields of health, mental health, early care and education, early intervention, hospitals, colleges and universities, legislatures, to name just a few.

There are 4 award categories: WAIMH Award, Sonya Bemporad Award, Serge Lebovici Award, Rene Spitz Award.

Required nomination materials for the WAIMH Award, the Sonya Bemporad Award, the Serge Lebovici Award and the René Spitz Award include:

1. A 250-500 word statement indicating why the nominee should receive the award.
2. A copy of the nominee's resume, vita, or biographical sketch. If you are nominating a group, provide a complete description of the group and its members as well as a

brief history of its relevant activities.

3. Three letters of support from individuals who endorse your nomination.

Submit all nomination materials in one packet and e-mail to the WAIMH Central Office postmarked no later than

December 31, 2017. The WAIMH Awards Committee will select each of these awardees.

WAIMH New Investigator Award 2018

WAIMH offers a special award for a promising new investigator.

The purpose of the WAIMH New Investigator Award is to recognize and encourage promising new investigators in infant mental health. The applicant must be a member of WAIMH or must be sponsored by a member of WAIMH. The applicant must have earned a university degree no more than eight years prior to the application deadline. The individual selected as new investigator receives a

cash award, a plaque, and acceptance of his/her paper for publication in the *Infant Mental Health Journal* (this involves exposure to the peer review process as a way of assisting the investigator's professional development). In addition, the new investigator must be prepared to present his or her work at the following world congress. We now call for applications for the WAIMH New Investigator Award.

Required nomination materials for the New Investigator Award include:

A statement indicating why he/she should receive the award

A manuscript of the applicant's research

A curriculum vitae

Submit all nominating materials in one packet to the WAIMH Central Office at office@waimh.org no later than December 31, 2017. The Programme Committee of the 16th WAIMH World Congress will decide the next WAIMH New Investigator Awardee after reviewing the applications.



The recipient of the WAIMH Award in WAIMH 15th World Congress in Prague 2016 was Pia Risholm-Mothander. The WAIMH Award is given in recognition of significant contributions to the World Association for Infant Mental Health, either directly or through one of the WAIMH Affiliate Associations.