

# Perspectives in Infant Mental Health

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## A Letter to the Editor

What appears below is a response from the ZERO TO THREE Diagnostic Classification Task Force, chaired by Dr. Charles H. Zeanah, to Professor Kai von Klitzing's article, "Should We Diagnose Babies?" posted July 11, 2017 in WAIMH *Perspectives in Infant Mental Health*. A brief reply from Professor von Klitzing follows Dr. Zeanah's response.



### Should We Diagnose Babies? No!

### Should We Diagnose Disorders in Babies? Yes!

By ZERO TO THREE Diagnostic Classification Task Force

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We appreciate Professor von Klitzing's article addressing the *DC:0-5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (ZERO TO THREE, 2016) in the previous issue of *Perspectives*. His remarks nicely summarized the major features of the recently published nosology. We completely agree that "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." We also acknowledge and are grateful for the constructive input from so many WAIMH members during the development of DC:0-5, including responses to online surveys, email exchanges, and formal comments and informal at presentations WAIMH Congresses. No doubt the nosology was strengthened by that input. We reviewed all comments thoroughly and made use of them as we conducted our work.

As emphasized by the title of his paper, Professor von Klitzing also reviewed a number of concerns about the wisdom and usefulness of diagnosing babies with psychiatric disorders. We understand that



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he is speaking not only for himself but for many WAIMH members who may share the reservations he expressed. In the spirit of critical discussion that he invites, we would like to respond to a number of interesting points he raised as a way of extending the conversation.

Professor Klitzing notes that controversy remains “within the international interdisciplinary infant mental health field (represented by more than 50 WAIMH affiliates) over whether the categorization of the mental health problems of infants by psychiatric diagnoses is adequate.” Before addressing the specific points following this general statement, we would like to state that the Diagnostic Classification Revision Task Force agrees unequivocally that the DC:0-5 is inadequate—as all nosologies must be. Our hope is that it is less inadequate than its predecessors and other available nosologies regarding the diagnosis component of the assessment. We hope that its use by practitioners and studies by investigators will clarify its inadequacies and move the field towards a more reliable, valid and useful means of identifying what we believe to be serious disturbances that too many young children experience. Ultimately, the hope is that a more effective system of classification will lead to the development of more effective treatments and a better pairing of existing evidence-based treatments with the infants, toddlers and families who would benefit from these treatments.

The Task Force believes that any diagnosis -- categorical or dimensional -- is inadequate to describe a child with sufficient complexity for clinical purposes. Nevertheless, parents, caregivers, and providers already categorize clinical presentations. Families functionally categorize behavioral and physical problems as something that is either developmentally typical or of concern, and then further determine whether the concern is sufficient to seek help. Providers also functionally categorize the clinical presentations as normative or requiring treatment. These dichotomies exist whether or not categorical diagnoses are used to describe the clinical presentation.

With rare exceptions, nearly everything about human bodies, emotions, behaviors, and relationships occurs on a continuum and not in categories. In physical health, as in psychiatry, the bounds of “healthy” and “unhealthy” are defined as specific points on the continuum. These points are informed by research and change as our knowledge expands. Examples in physical health include

hypertension, the level of allowable lead in young children's blood, definitions of obesity, and even the level of oxygen saturation defined as low and requiring supplemental oxygen (93% is defined as hypoxia, whereas 94% is acceptable). Similarly, nearly everything about the human experience of disease involves transactional processes among children's biology, relationships, physical and social environment, and the cultural values, beliefs, and practices of the family in the context of their community. No categorical diagnosis alone can fully reflect those characteristics. For example, for a child with recurrent bronchospasms causing difficulty breathing, identification of the categorical diagnosis of asthma is only one step in the clinical process. Specific pharmacotherapy may be recommended, but a sustained healthy state may only be attained if the child's surrounding is cleared of triggers like parental tobacco smoking, neighborhood toxic substances, and environmental pollutants, a process that requires substantial attention to other contextual issues such as the parent-child relationship, parental depression, and family access to financial and other resources that may affect adherence to treatment recommendations.

It is precisely because of the complex interactions among multiple aspects of a child's life that we elected to retain five axes in DC:0-5, facilitating a clinical formulation that puts these pieces together, identifies relations among the 5-axial characterization of the child and his/her environment, and focuses on those aspects of the family system that seem most modifiable. In the specific case of asthma, for example, it may be that parental addiction to nicotine and the parent's underlying depression have the highest priority in the effective treatment of the child's asthma. In a child with hyperactivity, treatment with a parent-child therapy may only lead to improvement if the child's elevated lead level is identified as a causal factor and housing conditions are addressed through lead abatement or relocation. While acknowledging the limitations of a categorical diagnostic system, we believe that considering all five axes of DC:0-5 should facilitate rather than preclude attention to the dynamic processes that affect a child's emotions and behaviors.

One objection raised by Professor Klitzing is that some clinicians believe that “the mental organization in early childhood is still so fluid that it is inappropriate to use relatively rigid categories to describe individual characteristics.” While mental organization is responsive to unfolding

developmental processes and changing circumstances, there is extensive research evidence supporting the validity of “syndromes” in the early years of life. Prospective, longitudinal studies of early childhood psychopathology have shown that emotional, social, and behavioral characteristics of young children are associated with family history, risk factors, and biological differences, and these characteristics show patterns of continuity and discontinuity that are remarkably similar to those found in older children and adults. The same studies have shown that in infants and toddlers (e.g., Briggs-Gowan et al., 2006) and preschoolers (e.g., Bufferd et al., 2012) social-emotional symptoms and patterns of symptoms show persistence (that is, homotypic and heterotypic continuities) similar to those found with older children. The level of persistence is consistent with findings reported by others who have studied this phenomenon in early childhood (Fischer et al., 1984; Lavigne et al., 1998; Mathiesen & Sanson, 2000) and parallels rates of persistence documented in school-age children (Briggs-Gowan et al., 2003).

In addition, we note that except for many of the neurodevelopmental disorders, most psychiatric disorders across the lifespan do not involve an unrelenting course but wax and wane over time. This is the nature of psychopathology. In fact, diagnostic stability from the preschool years to middle childhood is moderate and comparable to stability between middle childhood and adolescence. It is true that we know little about the stability of disorders that present in the first year of life, but there is symptomatic continuity from the second year of life into the preschool and even school-age years for ratings of emotional and behavioral problems (Briggs Gowan & Carter, 2008), overactivity (Leblanc et al., 2008), aggression (Hay et al., 2014; NICHD ECCRN, 2004; Wildeboer et al., 2015), and anxiety (Hirshfeld et al., 1992). Stability is greater when these symptomatic behaviors are more severe.

As for the concern that “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,” we suggest that members of the Task Force should be included among those clinicians and researchers who see relationship disturbances often manifest in the form of child behavior problems. This is the reason that DC:0-5 introduced the diagnosis of Relationship Specific Disorder of Infancy/Early Childhood. We believe that it is important to distinguish between

behavioral disturbances that are expressed cross contextually and those that are relationship-specific. We also encourage characterization of the child’s relational context (Axis II) for every diagnosis.

Professor Klitzing notes that “psychiatric diagnoses are associated with considerable stigma in nearly all societies” and that we run the risk of “burdening [young children] with diagnoses such as anxiety disorder, depression or autism spectrum disorder.” We argue that the stigma of mental illness is a deplorable social phenomenon that we all should endeavor to change by promoting knowledge, understanding, and empathy. It is also worth emphasizing here, as we do in the manual, that we diagnose disorders and not people. A young child has pneumonia or Separation Anxiety Disorder but is neither. For those concerned about the potential risks of diagnosing Anxiety Disorder, Depression, or Autism Spectrum Disorder (ASD), we ask them to consider the consequences of not naming the existing clinical syndrome. While words have power, there is also a powerful stigma in most cultures about the observable features of mental health problems. Children with atypical or aberrant behaviors or extremes of emotions are often labeled with words that have negative attributions, such as “bad,” “weird,” “manipulative,” or “spoiled.” Helping parents use language that offers meaning rather than blame can lead to a reduction in suffering that is already happening and can bring relief as well as a path to healthier development. In fact, clinical experience and research in the U.S. suggest that treatment engagement is higher when parents know their child’s diagnosis (Peters et al., 2005). This is one of the most effective ways of combating the destructive effects of stigmatizing those with mental illness.

Autism is a good example of the importance of making a diagnosis. Autism can be diagnosed reliably in the second year of life in most cases (Johnson & Myers, 2007; Woolfenden et al., 2012; Zwaigenbaum et al., 2016), and yet, for most afflicted children, it is diagnosed at a median age of 3 or 4 years of age in the United States (Fountain, King & Bearman, 2011). The delay between manifestations of developmental abnormalities and diagnosis is harmful because evidence suggests that earlier interventions for children with ASD are essential (Dawson et al., 2010; Schreibman et al., 2015; Zwaigenbaum et al., 2015).

Professor van Klitzing discusses the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) extensively, stating concerns that the diagnosis

became studied and accepted after the pharmacologic treatment was accidentally discovered. We appreciate (and share) his skepticism about the altruism of for-profit pharmaceutical companies. It is worth noting, however, that syndromes consistent with ADHD have been described since at least the 19th century (Lange et al., 2010). We hasten to point out that the accidental discovery of the attention-enhancing effects of stimulants was identified in a residential treatment facility for children whose behaviors were too disruptive to allow them to live at home. This is clear evidence that, while the categorical description did not exist in 1938 when Charles Bradley described the effects of benzedrine, the patients he treated had problematic, high levels of hyperactivity and impulsivity that prevented engagement in developmentally typical activities (Strohl, 2011). Contemporary professional treatment recommendations for ADHD in young children have been remarkably consistent in advocating the use of non-pharmacologic treatments, usually promoting interventions that address all five DC:0-5 axes, rather than psychopharmacologic interventions (AAP, 2011; NICE, 2006; Gleason et al., 2007; Gleason et al., 2016).

Professor von Klitzing expresses concern about “a strong tendency towards expanding this diagnosis both into adulthood and into younger ages” and notes that the DC:0-5 inclusion of ADHD and Overactivity Disorder of Toddlerhood as examples of this tendency. Here again, research findings support the continuity of these conditions. An international epidemiologic literature demonstrates that the trajectories of hyperactive/impulsive behaviors are stable for toddlers, meaning 18-month-olds in the top percentiles of activity become preschool children also in the top percentiles of activity (Galera et al., 2012; LeBlanc et al., 2008; Overgaard et al., 2014). It is important to note that high level of hyperactivity alone is not a diagnostic category. Only if the hyperactivity impairs the child’s functioning does it become a disorder. The literature indicates clearly that extremes of hyperactivity are clearly present in very young children.

Professor von Klitzing notes that comorbidity is the “rule rather than the exception.” In fact, this is true, not only in early childhood but throughout the life cycle. For him and others, this highlights the “general lack of distinctive validity of psychiatric diagnostic categories.” Specifically, he asserts that “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." Many co-morbid patterns are known to relate to prognosis, so we do not agree that co-morbidity is unimportant. In fact, the treatment of a child with ADHD and anxiety should be different than the treatment of a child with either alone and should attend to common underlying factors for the two disorders as well as factors specific to each.

We agree that descriptive classifications are deeply flawed, but lacking a better understanding of the neurobiology of psychiatric disorders and of their pathophysiology, a descriptive categorical system is the current state of the science.

Those who led the American Psychiatric Association Task Force on *DSM-5* (APA, 2013) had planned a dimensional approach to diagnosis, but the data were not available to support it. Disappointed by this failure, the National Institute of Mental Health launched the Research Domain Criteria (RDoC) initiative which aims to change the focus of research from categorical diagnoses to dimensions of disturbance. We wholeheartedly agree with Professor von Klitzing about the ultimate promise of tying emotional and behavioral symptomatology to underlying neurobiology. Nevertheless, there is no indication that RDoCs will yield changes in clinical practice for decades. No matter what dimensional approach is used, practitioners need to make a yes/no decision about clinical caseness: either the infant/young child needs treatment or not.

We understand that WAIMH will not "promote one diagnostic system," but we do invite the WAIMH community to participate in evaluating the value of DC:0-5. This effort needs to involve clinical usefulness as well as examinations of the validity of the diagnostic criteria and thresholds for determining diagnostic status. Such an endeavor will require multiple lines of inquiry. Our most fervent hope for DC:0-5 is that future research will refine, refute and affirm the approach that it outlines. This will require research that Professor von Klitzing is concerned may be of limited value, but at this point, we do not see dimensions and categories as an either/or clinical or research enterprise.

We appreciate Professor von Klitzing's nuanced and thoughtful discussion of DC:0-5, and we are grateful for the opportunity to extend the dialogue about these important issues. Diagnosis of problems in babies is a challenging topic—the very term "baby" elicits images of tenderness, hopefulness and innocence. Nevertheless, our field exists precisely because we know that young children suffer distress and functional impairment

as well as jeopardized development stemming from different types of psychopathology. As clinicians, we must guard against attributing to parents our own uneasiness about talking clearly and concretely about difficult topics. Instead, as a field, we need to move beyond a pro/con consideration of diagnostic approaches and endeavor to deepen our understanding of the young child in the context of his/her circumstances.

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# Diagnosing Babies? Diagnosing Disorders in Babies?

## Some thoughts on the ZERO TO THREE TASK FORCE response

By Kai von Klitzing, MD, Leipzig, Germany

Recently I conducted a diagnostic session with a 25-month-old boy and both his parents. The parents were very fond of their boy, who was their first child, but they were also convinced that he was severely disturbed. They regarded him as extremely overactive and impulsive, told me that soon after birth he would hold his head high in order to anxiously observe his environment, always appearing very tense. I knew that there had been many problems during the first years, starting with a delivery which the mother had experienced as traumatic, a long period of postnatal depression, feeding problems, etc. The mother had subjectively experienced her boy as aggressive and hostile, and herself as insufficient. The father somehow agreed to her way of looking at things. During the session the boy was constantly moving around, exploring, somehow shy towards me, but nevertheless approaching me because he wanted to have the pen in my breast pocket. When I said “no” but gave him some colored paper instead, he was satisfied for a while but then started to beg for my pen again. From time to time he went to both parents, sat on their lap for a few seconds, but then separated and continued to move around. He knew and expressed some words, especially “no”, when his parents limited dangerous activities.

During the session I thought about my short paper in *Perspectives* and the thoughtful response that we received from the Zero to Three Task Force (ZTTTF). Should I make a clear statement that the boy has a diagnosable disorder, and if yes, what could be the right diagnosis? Was the level of observable activity and impulsivity beyond “developmentally and culturally expected norms”? There was clear impairment, at least in the parent-child relationship; the parents suffered, and this also caused suffering in the boy. I felt insecure and thought of attending one of the next available Zero to Five training courses. If I assumed that the observed behavior was within the norms, then it could be a relational disorder, because the problematic behavior might only occur in the relationship with the parents. But the boy’s behavior towards his parents did not seem to be abnormal. It was abnormal in the minds of the parents: there seemed to be a disorder in their “enfant dans la tête” (Soulé, 1982). What counts? The clinical observation and the norms of the clinician, or the internal reality and norms of the parents? What I saw supported my agreement with the concluding statement of ZTTTF that we have to acknowledge that young children (and their parents) “suffer distress and functional impairment as well as jeopardized development stemming from different types of psychopathology.” The diagnostic process with young children is so challenging because the interpersonal and intrapsychic aspects are inextricably linked to each other in the early years.

### Continuity vs. discontinuity of symptoms and disorders?

But there are also risks. What does the communication of a diagnosis mean for the course of further development? From preschool age on there seems to be some continuity for example of hyperactivity symptoms into adolescence, but in general the level of symptoms decreases over time (Lahey et al., 2016). Meeting the criteria of an early diagnosis predicts functional impairment over time fairly well, but is much less reliable in predicting the stability of a specific disorder (Biederman, Mick, & Faraone, 2000). On the other hand, we should not forget that establishing a diagnosis is also a way of intervention,

maybe not always to the better. For example, telling parents that their toddler’s problems seem to be best characterized as specific disorder might enhance their understanding of their child’s behavior on the one hand, but can also lead them to a parental attitude to protect him/her from age-adequate developmental challenges and to developmental restraints on the other.

### Categorical vs./and dimensional?

Without doubt I support the ZTTTF notion that developmentally sensitive diagnoses describe patterns of symptoms and impairment and not children’s traits. My research group is currently conducting a longitudinal study on internalizing symptoms and anxiety/depression disorders from preschool to late school age. We use both categorical and dimensional approaches to describe early internalizing problems. My impression is that the longitudinal description of symptom trajectories is better suited to describing the developmental dynamics of psychopathology than the early application of diagnostic categories. I agree that the decision to recommend therapeutic intervention or not is also a categorical decision. But this decision might be better served by assessing risk profiles (Bufferd et al., 2014) such as temperamental characteristics, parental psychopathology and/or early life stress than by applying early diagnostic categories. We should treat infants and their parents when they show high-risk profiles even if the symptoms do not meet diagnostic criteria. Studies on the course and taxonomy of psychopathology have shown that higher-order dimensions like externalizing/internalizing or even general psychopathology factors show more continuity than more singular criteria of categorical diagnostic categories (Forbes, Tackett, Markon, & Krueger, 2016; Kotov et al., 2017).

## Comorbidity or heterogeneous symptom clusters?

I fully agree that we would treat a young child who exhibits anxiety and overactivity differently from a child with activity problems alone. Nevertheless – as (Goldberg, 2015) rightly argues – the notion of co-morbidity is misleading. “The term ‘co-morbidity’ was introduced in medicine to denote those cases in which a ‘distinct additional clinical entity’ occurred during the clinical course of a patient having a particular illness. Thus, while a person with both schizophrenia and peptic ulceration might reasonably be said to have two co-morbid disorders, a person with major depression and an anxiety disorder cannot—the illnesses are not really distinct. The illusion of the DSM-5 approach to common mental disorders can really only be sustained by drawing borders where none exist” (p. 2). I would hypothesize that this is even more so in early childhood. In the case of the young child with anxiety and overactivity symptoms, a clinical appraisal of whether the child expresses his/her anxiety through motoric activity might be more helpful for setting up psychotherapeutic strategies than a concept of the child having two co-morbid disorders, each of which needs a different approach.

## Extending the concept of ADHD to early childhood?

Just as I agree with the ZTTTF that we must overcome our own uneasiness about clearly and concretely talking about young children’s difficulties and disorders, I am still very skeptical with respect to extending the concept of ADHD to early childhood. Recently I asked a 6-year-old in our child psychiatry unit why his parents had brought him to the hospital, and he responded: “I was brought here because I am ADHD!” This shows how essential it is that we should diagnose disorders and not children, and I am very grateful to the ZTTTF for emphasizing this clearly in its statement. Nevertheless, a diagnosis, and especially an early one, can have a tremendous impact on the child’s self-concept, and the parental concept of their child as well. In fact, there are data which show that high levels of motor activity, impulsiveness, and especially inattention can predict more severe problems in later life, but hyperactivity symptoms usually decline as the child grows older and the predictions are less syndrome specific and more valid with respect to global functioning and developmental impairment (Biederman et al., 2000). Excessive motor activities can be seen as first precursors of ADHD and are observed by parents as early as

their child’s toddlerhood, but they are barely distinguishable from highly variable normative behavior during the first years of life. I appreciate the clarification from the ZTTTF that their members advocate for non-pharmacologic treatments, but I still remain hesitant because experience shows that when a disorder concept is broadened to include new age groups, the next step of introducing the pharmacological treatment is usually not far away. We have seen this trend in the USA, where the extensive increase of bipolar disorder diagnoses during childhood led to a tremendous use of drug treatment for children, a tendency that was not seen in Europe or other continents. I thank ZTTTF for reminding us that the first use of benzedrine, a drug containing amphetamine, in children initially led to positive effects: Hyperactivity decreased and concentration increased. But Bradley (1937) already warned: “Any indiscriminate use of benzedrine to produce symptomatic relief might well mask reactions of etiological significance which should in every case receive adequate attention.” (Bradley, 1937). Amphetamine was soon bought on the black market because it mobilized power and enhanced self-confidence. Methylphenidate was first synthesized by Leandro Panizzon in 1944 for the Swiss company Ciba. In a self-trial, his wife took the substance and responded enthusiastically because her abilities to play tennis improved dramatically. Panizzon named the drug “Ritalin” because of his successful wife’s name Rita. It was brought to the market in 1954 and blazed a trail of success that is still ongoing after more than 60 years.

Although I have expressed some concerns, I want to thank the members of the Zero To Three Diagnostic Classification Task Force for the enormous work they have done in assembling all the clinical experience and scientific knowledge to create this new version of the classification system. I also thank them for being open and flexible enough to deal with the critical discussion that I know is conducted in the international infant mental health field. There are arguments for and against, coming from different clinical concepts, scientific approaches, and cultural backgrounds. Listening carefully to what clinicians and scientists from diverse cultural and professional backgrounds have to say and dealing with their concerns in an open, respectful discussion is essential and will move our field forward.

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This issue, the final one of 2017, is dedicated to the well-being of all babies and families around the world. These are turbulent times. As Kai von Klitzing, WAIMH President, challenged us last year "... *in the long run, if we want to protect our social environments from destabilization and from populist ideas taking over our hearts and those of our fellow citizens, we must advocate for an improvement in the living conditions and relational experiences that the societies of the world offer to their youngest members.*"

## From the Editors

The WAIMH community at large has the capacity to impact the physical, developmental, and psychological health of very young children and their caregivers around the world. By working together, we can change the trajectory from certain risk to improved outcomes – but, it will take each and every one of us to contribute – as scientists, as university faculty, as clinicians, as developmental specialists, as early care and education providers. Arthur Miller, American playwright, wrote, "We are all in this together..." We are - babies are - families are. Together, we can make a difference. Hope lies in the relationships we enter into and sustain through our work with, or on behalf of babies and families around the world.

This has been a year of change for WAIMH *Perspectives*. In addition to publishing issues throughout the year, we, with assistance from Minna Sorsa and Reija Latva, used social media more intentionally, posting single articles on the WAIMH Facebook page. We hoped this format would encourage dialogue about issues that are critical to the WAIMH community, e.g. "Should we diagnose babies?" and a response from the Zero to Three Task Force, "Should we Diagnose Babies? No! Should we Diagnose Disorders in Babies? Yes!"

Other articles that appeared in *Perspectives* this year included the WAIMH position paper on the Rights of Infants, a careful examination of infants' rights by Maree Foley and Miri Keren, and a focus on *the worldwide burden of infant mental and emotional disorder* (A WAIMH Task Force initiative led by Karlen Lyons-Ruth). Consideration of cultural practices within community support services were featured in both the World in WAIMH and the Affiliates Corner. Profiles gave us a window into the interests and professional lives of WAIMH Board of Directors. Reviews of several books introduced us to new ways to support infant mental health practice.

We end the year with thanks to the WAIMH Board of Directors, the WAIMH Central Office staff, and the many members who have enriched our thinking through contributions to *Perspectives*. We welcome submissions that challenge the way we currently think about infancy and early parenthood, assessment, intervention and treatment. We invite scientific studies and clinical case reports, reports from the field, new resources, and books reviews. We end the year with wishes for greater understanding and peaceful coexistence in communities across the world.

## 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, Deborah Weatherston, [dweatherston@allianceaimh.org](mailto:dweatherston@allianceaimh.org)



# The World in WAIMH

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## Introductory Remarks by Joshua Sparrow

When infant mental health workers attempt to repair the disruptions of family eco-systems caused by natural or human-made disasters in cultures different from their own, they often bring interventions from their own cultures, along with the unexamined belief systems and cultural constructs that underlie them. Their understandings of those of the cultures they intend to work in are often understandably limited. Their interactions with those they intend to serve are also often marked by the trajectory of colonization and decolonization.

Cultures, in general, are dynamic rather than static. They evolve as they interact with other cultures, and in response to forces such as changing physical environments and new pressures on survival. In this important reflection, French interventionists working in Haiti after the devastating 2010 earthquake consider the encounters of their belief systems with local ones, and the stresses on the latter due both to the former and to unprecedented trauma and loss.

This qualitative summary paints a powerful picture of infants and parents who have experienced devastating losses that impact the health, emotional well-being and feeding relationship for both mother and child.



## Considering cultural practices within a psychoeducational community support service for mother-infant health care: Field report

By Mayssa' El Hussein, PhD, France,

Leyla Akoury Dirani, Lebanon,

Rami Elhousseini, Lebanon

and Marie Rose Moro, France

The massive earthquake that ripped open Haiti in January 2010 heavily impacted a population already living in precarious socio-economic conditions (Hurbon 1987; Pierre et al 2012). A few months later, in that same year, the cholera epidemic struck. The Haitian population and the humanitarian services were in shock. The earthquake left more than 230 000 dead and 220 000 injured. Cholera took the lives of about 8000 people and infected thousands more. Every family in the country was affected, grieving over a loved one who was lost, lost property and livelihoods, or living with the fear of losing a sick family member. These crises led to a reinforcement of the presence of international NGOs' humanitarian services provided by international NGOs (El Hussein 2015). Some NGOs offered healthcare services, while others offered psycho-educational and preventive activities in addition to healthcare.

This paper presents illustrations of the work of international NGOs with Haitian caregivers and young children following significant humanitarian crises. At the same time it raises important social and cultural questions about the interface of Euro-American practices within the cultural fabric of the Haitian community. It is not an exhaustive study of the humanitarian interventions and their impact on the Haitians' cultural beliefs, but illustrates some of the barriers and also possibilities to effective intervention when there are social and cultural differences between those providing the services and those receiving them.

### Method

Following the earthquake in January 2010, the cholera outbreak in October of that year magnified critical concerns related to maternal and infant health, particularly the infant's nutritional health. Due to the high death rate, many families were unable to perform proper burial rituals for the deceased. For many Haitians, bereavement without honoring the dead affects mothers' milk, which can, as a result, become poisonous. This led to the community's decision to encourage mothers to feed their infants artificial powdered milk diluted with water rather than to breastfeed their infants. In contrast, the European NGO decided to intensify its community health activities by promoting awareness of the importance of breastfeeding through educational sessions.

Naturalistic observations were collected throughout the implementation of two activities organized by a European NGO in Petit Goave-Haiti: LANPE (Lait Artificiel pour Nourrisson Prêt à l'Emploi) and AME (Allaitement Maternel Exclusif). The observer was a Lebanese clinical psychologist enrolled in a European NGO and serving in Haiti after the earthquake of 2010. Coming from a multicultural/multi-religion country and having worked for 6 years with international NGOs in her own country, this clinician was already attuned to the delicate endeavor of intertwining external knowledge and beliefs with those of local communities.

Analysis of the observations collected were drawn on the principle of complementarism as defined by the widely influential French ethnologist and psychoanalyst, Georges Devereux (1978) regarding psychological understanding of human beings: The author highlights the necessity of resorting to different but complementary perspectives in the understanding of a human phenomenon, such as the anthropological and the psychological perspectives. Moreover, Devereux insisted on the major impact of the observer's reactions and feelings on the observed phenomenon and therefore on his/her understanding and analysis. In this perspective, the observer used a multi-pronged approach as she carried out her observations:

- An ethnological exploration of the rituals and representations concerning pregnancy, birth and breastfeeding among the different ethnical groups in the regions of Grand Goave and Petit Goave;
- A psychoanalytical approach consisting of the analysis of her own countertransference reactions towards the persons observed, the group dynamics among the participants, the animators of the groups and herself as well as her internal reactions to the information collected from the informants. Informants were Haitian persons from different backgrounds: nurses, teachers, oungans (Voodoo priest), and pastors from different religious affiliations: voodoo, Catholic, Protestant and Muslim (only one Muslim informant knowing that the Muslim community in Haiti is very small). Information was also collected from readings of sociology and anthropology books from Haitian and international authors.
- A psychological approach consisting of practice analysis groups (regular meetings designed for reflection on our practices, preconceptions and

cultural barriers that we confronted during the field work) with the team conducting the activities of LANPE and AME described later in this article.

Observations were collected from the two phases of the project. The first phase was exploratory and lasted one month. The second phase consisted of the actual implementation of activities of LANPE and AME and lasted 10 months.

During the first phase, observations were collected during field visits, meetings with the local teams of facilitators and organizers, reading training documents pertaining to the facilitators group and reviewing previous evaluation reports of other activities. The findings of the first phase led us to add the psychosocial and cultural dimensions to the mother-infant health care activities.

During the second phase, observations were collected directly from the LANPE and AME implemented groups' activities. Full day observations of mothers and their newborns who participated in the activities were conducted twice a week. The participants were divided into two groups: morning and afternoon.

The team of professionals/facilitators was composed of 20 participants: the Haitian coordinator of the community health program, a Canadian coordinator of the infant nutrition program, and the Haitian nurses and facilitators. All members of the team were females. Weekly meetings of 90 minutes each were held for the full duration of the study (10 months).

## Two Groups: Description of Activities

1. LANPE (Lait Artificiel pour Nourrisson-Prêt à l'Emploi - ready to Use Baby Formula): Nurses led this activity in a primary care center in the city of Grand Goave. The participating group was composed of 60 mother-infant dyads. The mothers were either female adults in charge of the baby after the death or abandonment of the biological mother or biological mothers unable to breastfeed. Infants were between two and six months of age. Nurses provided the mothers with information about feeding, keeping the baby clean and handling the baby. They also demonstrated these skills.

During the first week, mothers and babies came every day to monitor the baby's reaction to the artificial milk, and then, once per week for general checkups. The babies spent half the day at the primary care center (from 8am until 2pm). They had

two meals and a nap. A nurse bathed some of the infants. At each visit, the babies took their first bottle of the day, were weighed, their temperature was taken, and the weekly ration of milk was provided to the mothers. For any health problems, babies were referred to the primary care center's pediatrician.

2. AME (Allaitement Maternel Exclusif - Exclusive maternal breastfeeding): This activity was implemented with great difficulty, either because of limited access in rural areas, or due to the lack of closed spaces in the city, where public spaces would bring in numerous distractions. The purpose of the activity was to provide an awareness and prevention program for pregnant women (7-8 months gestation) and new mothers with babies (11 days to 6 months of age). 180 women participated in 16 sessions. Sessions presented the benefits of exclusive breastfeeding. The facilitators decided on the time and place where the groups would meet. All sessions started with a collective song to promote exclusive breastfeeding. While meeting with the team of professionals during the exploratory phase, we heard them repeatedly use the terms *ignorance* and *false beliefs*. Ignorance referred to lack of knowledge about the benefits of breastfeeding, and the infant's nutritional and hygienic needs. *False beliefs* referred to mothers' beliefs about adverse effects of breastfeeding, e.g.: a breastfeeding malnourished mother will become extremely weak, a grieving mother will have poisoned milk. Also, while reviewing the training documents, we found that they included a list of recommendations for the facilitators, prepared by a cluster of European NGOs, about addressing these false beliefs with the mothers. In order to get a clear idea of the "false beliefs included in the training documents, interviews were conducted with the facilitators in the field and other informants in the community in order to gather a comprehensive list of what they were asked to consider as false.

## LANPE Group: Ready to Use Baby Formula

During the implementation phase of LANPE (the Ready to Use Baby Formula group), the observer noticed that participants were a bit shy at the beginning of the day. However, after the first meal, women started chatting, and then at lunch time they were so comfortable with each other that they were willing to hold or supervise each other's babies, to leave and return. The group became a safe and containing holding environment

for mothers, supporting them when they struggled to care for their babies. There were difficult moments when a mother felt challenged by her new mothering tasks and compared herself unfavorably with the “good mothers.” The nurse was attentive to these dynamics. Her role was not only to provide care but also to help the mother to feel secure within the group environment. By protecting the mother, supporting her psychological journey and resources, the nurse helped each mother to restore her sense of self, which in turn made each more equipped to take care of her baby.

In one of the LANPE sessions, the observer noted the interaction between E. and his mother. E’s mother reported that she could not breastfeed her child because of her “*severe anemia, a stomach ulcer, and an ill breast; so her physician asked her to stop breastfeeding*”. E. caught our attention. At 2 months, he looked sad and stared blankly, barely interacting. While sleeping, he made us think of a dying child. His mother also had a remarkably sad gaze and avoided eye contact. Nurses reported that the mother felt suffocated when she breastfed. Nurses interpreted these sensations as symptomatic of anemia and ulcers, concluding that by continuing to breastfeed, the mother would lose her remaining energy. The psychological state of the dyad was not mentioned or specifically reported at the time.

The observer was also struck by baby CH, 2 months old, and her aunt, her substitute mother. Baby CH cried a lot while her aunt was busy dressing her. Another substitute mother told her “*she should hold the baby*.” A nurse held the baby, cradled her and sang to her. Then, another substitute mother took the baby, sang to her and played with her. CH’s aunt watched this lady and was amused, but only smiled at her.

In one of the AME sessions, a mother asked whether *burn out impedes breastfeeding*. This question pointed to the relational dimension of breastfeeding. Breastfeeding requires a mother to be “good enough,” to be available to hold and contain her baby. During a breastfeeding encounter, a lot is transmitted: the mother’s gaze, her love or her anxiety, her wellbeing or her distress. Indeed, burn out may affect breastfeeding because the mother may not feel she is available to interact. If this is the case, breastfeeding may soon become a very difficult task. However, the facilitator answered the question without exploring further. She said simply, “*Burn out does not affect breastfeeding*.” Had the facilitator asked the mother to elaborate further, then the psychic dimension of breastfeeding or the relational issues between the mother

and her baby could have been explored. The possible psychological distress of the mother (guilty feelings, anxiety about being a bad mother, regression) might have been addressed.

In another group, a participant looked sad, avoiding her baby while the facilitator was promoting the benefits of exclusive breastfeeding. In fact, this mother didn’t have milk to give her baby. In another conversation, we learned that this mother had been pregnant during the earthquake. She had been informed that her uncle had died, information that she kept to herself to protect her relatives from a complete collapse, in particular, her own mother. She kept her grief a secret for a month, not able to share it with her relatives. This mother had identified the cause of her inability to breastfeed as grief. In this case, the facilitator did not seek to investigate her reasoning any further but had systematically referred the mother to the LANPE group. The cultural adoption of causality between grief and “dried breasts” appeared to be a common understanding in this Haitian community, and did not require an alternative explanation.

## Reflections and clinical interpretations

These feeding experiences can be understood as relational moments, from our perspective. Based on the Euro American established psychological paradigm in mother infant observation (as applied by the likes of Tavistock clinic in the U.K., GERPEN in France, Martha Harris Study Centers in Italy, and the Washington School of Psychiatry) significant interpersonal dynamics may be explored during the feeding experience. However, in the LANPE setting, the facilitators were not prepared to use the feeding experience as a time for psychological exploration. They simply answered the mothers’ questions about milk production directly, and offered them the use of artificial milk for their babies. The same was true for the AME group, where the facilitators simply explained the importance of exclusive breastfeeding.

In times of catastrophes when a community is vulnerable and socio-economic difficulties are exacerbated, mothers and substitute-mothers may seek NGOs help. LANPE groups and AME sessions could be safe spaces where emotional needs may emerge. They may have the function as a “transitional space” as per D.Winnicott (1971). This space of temporary containment and support, can introduce women to

palliative approaches in times of crises. The moments at the LANPE and AME programs provide a reprieve for mothers and babies from their daily-life, encapsulate them in a special time and space, and help them establish a sense of continuity and community. Bonds between groups of dyads and nurses or facilitators are therefore established as safe and therapeutic. This transitional space offers the possibility for reflection about mother care and motherhood and the beginning of the mother-baby’s bond.

The LANPE allows focusing on the care provided to the baby, the mother-baby interaction, and the physical availability of the mother while feeding. The nurse has the nurturing role giving the milk to the mother, supporting her in case of difficulty. A mother can identify with the nurse and with the other mothers interacting with their babies; she can also rely on other mothers when having a hard time with her child, as described for baby CH. A crying baby, constantly dissatisfied, may trigger in his mother a feeling of failure. A depressed or anxious mother, unable to invest in a peaceful relationship with her baby, finds herself in a vicious cycle in which the baby’s cries make her feel more distressed. Seeing her baby smile and become quiet in the arms of another mother may at first awaken feelings of rivalry and inadequacy, yet the support and validation from the group seemed to allow a mother to discover another face of her baby and herself. Mothers who come to the group with guilty feelings, failure, rivalry, etc. may benefit from a nurse/facilitator who can take note of these issues.

For all these reasons, the LANPE may serve as a pivotal space for prevention and early intervention, to support the mother-baby dyads in a critical moment when options remain open. It is a phase when the attachment relationship between baby and mother/substitute mother is built, often after an abrupt separation: a sudden weaning for medical reasons, or a more devastating separation, the death of the mother, or the abandonment of the baby.

While facilitating the awareness sessions of the AME, facilitators emphasize the nutritional component of exclusive breastfeeding, the hygiene of the baby and the mother, and educate participants using nutritional and economical arguments. The relational dimension, if it were addressed, might explore psychic, inter-generational and cultural nuances and modalities.

The educational aspect of the sessions reassures pregnant women about the

good quality of their milk, allowing them to dream about their baby's healthy development and to fantasize about breastfeeding moments. The group is potentially a space to contain the anxiety of participating mothers. It is a space where each mother can ask questions and express her worries about the milk nourishing her baby, provided that one takes the time to listen to each mother's discourse and the anxiety it carries. Making room for psychological expression would complement the focus on medical and nutritional knowledge.

## Ruptures in the cultural dimension

Something about the potentialities of these two spaces was interfered with. Beliefs related to the *cultural birthplace* (Moro 1994) of these mothers remained hidden, reduced to the notions of *false beliefs* and *ignorance*. These notions were overly emphasized in the teams' meetings and debriefing, as well as within the training delivered to the Haitian team.

Culture offers a logical understanding and traditional causal hypotheses that reassure the mother who cannot breastfeed and frees her from her guilt. The cultural etiology encrypts these anxieties in the collective representations trans-generationally transmitted. Collective crises and potential traumas may create a rupture in the continuity of the cultural transmission, This includes the massive intervention of NGOs, and their disruption of the long-established harmony between Euro-American medicine and traditional Haitian culture that Haitian society had evolved. This resulted in a defect in the cultural envelope that protects collective representations. When traditional and internalized collective convictions are shaken, a door to doubt and confusion is opened. The new transmissions that the NGOs dispense penetrate these openings and act as external objects that are difficult to integrate.

Concepts of "false beliefs" and "ignorance" were used by the NGO to refer to a cultural heritage transmitted from generation to generation, from mother to daughter, from mother to mother to be. Despite the new knowledge's consistency with the medical perspective, the message conveyed through the disruption of certain cultural beliefs can be experienced as profoundly paradoxical, especially if it is not intertwined within the cultural canvas.

These sessions occur in remote meeting places which require both parties to

walk up to four hours. Therefore, they address a group of people that relies only on the knowledge of its ancestors. The introduction of new and strictly medical knowledge, knowledge that is not in harmony with knowledge that is culturally transmitted or perhaps opposed to it, may not be readily accepted or assimilated. To illustrate this, in one of the AME sessions, while the facilitator was presenting hygiene precautions, an old lady sitting nearby, told a mother she shouldn't breastfeed. Two contradictory messages were simultaneously conveyed to the mother.

## Recommendations

Reaffirm the legitimacy of cultural knowledge: new understanding and intervention

Psychosocial responses to collective crisis are of paramount importance, however they involve, among other factors, social and cultural dimensions that warrant extensive exploration. As psychosocial interveners in humanitarian contexts, deepening our cultural knowledge regarding the field we are working in seemed to be an important but insufficient step. It needs to be hinged on a more profound psychological process which entails the exploration of our own cultural otherness regarding the culture we are encountering. Another major concern is related to the carriers of our external knowledge: the Haitian facilitators and nurses coached and trained by foreigners and working with a vulnerable population.

In the Haitian culture, mother's milk has a pivotal meaning. It carries the emotional bond between mother and child and it may heal or harm the child's health. Excluding this cultural belief creates a rupture in the cultural transmission. It denies to the facilitator the access to the internal mental representations of the participants, as well as to their own.

This denial is subtly perceived in certain awareness sessions when a facilitator gives the participant a direct and closed answer to a question. By systematically and solely referring to the knowledge received during the training, facilitators are preventing themselves from providing culturally sensitive recommendations.

Based on our first sets of observations, and to address the cultural rupture, we explored the cultural representations of femininity and maternity in our meetings with the facilitators. We wanted to enable the professionals to understand the situations and conflicts that may

potentially harm the relation between the mother and the infant, preventing her from breastfeeding him and/or building a good enough relationship.

This exercise provided a space for active listening, allowing the expression of anxiety for "both parties": the observer and the Haitian facilitators. All professionals explored again their cultural representations, allowing themselves to self-reflect. As an expatriate, the observer could reflect again on her personal collective cultural representations along with the facilitators. They realized then that reducing the resistance of the mothers to an irrational fear reflects their own defense mechanisms towards the resurgence of ancient cultural beliefs considered as obsolete. These beliefs had to be repressed by the perceived necessity to identify with Euro-American civilization.

Representations about pregnancy and delivery were awakened during the meetings with the field workers. They delved into their past and found the theories pertinent to their culture. For example, if a death occurs in a family, a pregnant woman doesn't wear traditional attire that signals "grief" and doesn't participate in the funeral. A pregnant woman is protected from sorcery throughout her pregnancy; a breastfeeding mother may have salted milk that kills the baby. Illness in the Haitian culture is complex and has a completely different meaning than in the western culture. Illnesses can be natural, sent from God, the *Lwas*, or the devil. Each category has its referral system: Euro-American medicine, traditional medicine or a combination of both. The traditional medicine relies on *doktè fey* (leaf doctor), or *oungan* (priest); a healer can master both skills.

During the discussions with the professionals, we noticed that certain traditional references are integrated and accepted without question. For example, a mark on the skin of the infant is a mark that shows the mother's desire for an unavailable food item. The imperative to bury the placenta to avoid sorcery, is another example, and the salting of maternal milk when she grieves, making the milk poisonous to the infant. As these beliefs and rituals were re-evoked, the facilitators became keener to embrace their own mothers' and grandmothers' stories. Their reactions and feedback to the mothers-participants became more nuanced, allowing more space for spontaneous expression. They became able to pause and turn away from the Euro-American knowledge for a while, to listen to the mothers' own representations about breastfeeding and delivery, inviting

them to share this common knowledge with the group. This, in turn, helped the transmigration of hybrid knowledge – inasmuch as Euro American knowledge is a melting pot of beliefs and empiricism – into the previous representations and to integrate it instead of rejecting it as totally strange to the culture.

To summarize, globalization is also globalization of conflicts and globalization of emergency response. This valuable endeavor is vital to peoples struggling with poverty and general social and governmental disruptions in times of crisis. International NGOs involved in rescuing and providing psychosocial support to local peoples face major challenges: preparing and protecting their staff in emergency contexts, understanding the local culture, and adapting their tools and interventions to the recipients' needs and belief system. The challenge is to act immediately and efficiently using a culturally sensitive approach as recommended by the IASC (2014). However, the understanding of "culturally sensitive" is not defined clearly and presents two major blind spots: culture is not an entity but an ongoing and multi-layered process; local staff representing this cultural knowledge are not often offered the possibility to discuss and object openly to what may be considered as 'scientific' and 'more developed' Euro-American knowledge.

To ensure adequacy and efficacy of their services, the International NGOs need to include an ethnological perspective while applying psychosocial interventions. Their programs can account for cultural specificities by providing a safety net to the facilitators i.e. waiving the requirement to apostatize in order to get remunerated. Interviewing local community members about their preferences and their beliefs prior to the implementation of the intervention, and creating focus groups that run concurrently to the implementation allowing self-reflection and adjustment of the material to the local population are key to enhance the success of any foreign psychosocial intervention.

## Conclusion

A newborn's survival largely depends on the care the ambient/sufficient environment provides. This environment is assumed to be good and strong enough to offer nutritional, hygienic, medical and, as importantly, emotional care. In a stable environment, giving birth provokes major

psychic changes in the mother's mind. She needs for herself first, a supportive and containing environment to be able to contain her baby's emotional distress. The elaboration of the mother-baby dyad is a delicate process, permeable to any disturbance with serious repercussions to both mother and baby.

In 2010-2011, the already vulnerable Haiti population, struggling with losses, fears, and the threat of death, received services through different activities (El Husseini 2015). LANPE and AME activities are implemented in a specific cultural setting, loaded with mental and spiritual representations. A retrospective question is posed: Is the Western medical discourse providing reassuring answers? In the Western discourse, an illness of the baby or the mother is defined and labeled as per specific criteria leading to diagnosis and treatment. In the Haitian culture an illness has mixed meanings. It is physical as much as it is spiritual. Are the spiritual beliefs taken into account while presenting the Western concepts?

This paper does not pretend to answer these fundamental questions. In order to be successfully adapted to other cultures, Western psychosocial interventions must not overlook or neglect spiritual and cultural dimensions of illness and health. When one wants to implement services one should primarily consider these elements. Understanding local resources and culture may facilitate the reception of new ideas while supplementing local assets, rather than engaging in acts of cultural imperialism, in which external knowledge – that may be irrelevant and possibly detrimental – is imposed with the assumption of its superiority.

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# Personal Communication: Treating Infants and Young Children Impacted by Trauma: Interventions that Promote Healthy Development

## - Joy Osofsky, Stepka, P.T. and King, L.C. (2017)

By Joy Osofsky, PhD, Department of  
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When the American Psychological Association asked me to write a short book, to be included in a trauma series, about the impact of trauma on infants and young children and evidence-based interventions and treatments to promote healthy development, I said, "Yes!" right away. I welcomed the opportunity to raise awareness for a broader audience, including undergraduates and graduate students, about the fact that young children in the first three years of life experience a higher percentage of trauma exposure than any other age group. It is also important to recognize that trauma exposure in the earliest years can not only lead to individual and family problems, but also can result in vast societal costs needed to help and support development. This book also provided the opportunity to help readers recognize that the first few years of life is a particularly sensitive time for brain development as well as cognitive, social and emotional growth and that adversity because of, or as a result of, trauma experienced in the first few years of life may be particularly detrimental developmentally. Findings from the landmark Adverse Childhood Experiences Study (ACES) have indicated that children experiencing trauma and other adverse experiences in the earliest years (e.g., domestic violence, abuse, neglect) are at increased risk for difficulties during middle childhood and adolescence and physical and mental health problems in adulthood (e.g., depression, anxiety, heart disease). In addition, the ACES study demonstrated the societal cost of exposure to trauma in early life. This study has shown that individuals with greater numbers of adverse childhood experiences were also more likely to experience social problems, such as unemployment, family violence and parenting problems, as well as a higher use of health and social services.

It is important for those receiving training in both child development and mental health or behavioral health disciplines to understand that trauma, either recognized or unrecognized, contributes to mental health symptoms in young children – and also that some groups are more vulnerable. For example, research has shown that 49% of children living in poverty have been exposed to trauma, and that they are 2 to 5 times more likely to be exposed to violence. A dose-response effect of childhood exposure to trauma has been found such that cumulative trauma places children at higher risk for long-term problems.

My experience over the years in developing and implementing the Louisiana State University Health Sciences Center Harris Center for Infant Mental Health and collaborating with others through the Harris Professional Development Network and in working with WAIMH and Zero to Three has helped me and others learn ways to dispel the myth that young children are not impacted by trauma. Further, there is good evidence that early intervention and treatment can make a difference. A main goal in writing this book has been to: 1) develop a resource to educate psychologists, psychiatrists, social workers, counselors, pediatricians, child development specialists and other health professionals about the impact of trauma on young children and 2) to describe several widely used evidence-based treatments, Child-Parent Psychotherapy, Parent-Child Interaction Therapy, and Attachment Biobehavioral Catch-Up Intervention that are effective in helping these children. In order to better inform the reader about these treatments, we provide a "roadmap" in the book related to the criteria that can be used in making decisions about which treatment might be most helpful for an individual child and caregiver, including how they are used, for what age children they are most effective and why a clinician might choose

one treatment rather than another. The importance of behavioral observations and play is also discussed to help the reader understand the ways that young children communicate their feelings before they are able to use language.

The three treatments described in this book include a developmental understanding of expectable behavior in young children and integrate a socio-cultural perspective related to background and beliefs in working with children and families. Emphasis is placed throughout on the importance of the parent-child relationship in supporting infants and young children who are exposed to traumatic events because their sense of security comes from positive experiences with trusting, nurturing relationships. The reader will learn how sensitive relationship-based therapy can be helpful in modifying earlier negative experiences and perceptions.

In conclusion, it is important to raise awareness and provide increased information about infant mental health theory, research and treatment in training programs for all developmental and mental health professionals. Although infant and early childhood mental health has recently become integrated into some training programs and clinical care settings, there are still a limited number that include a comprehensive understanding of infant mental health theory, research and treatment in their curriculum. And yet, there is now abundant evidence not only about the need, but also information about evidence-based treatments that are effective for very young children,

Early identification, evaluation and treatment benefit from specialized training, as often the traumatic responses of infants and young children are misinterpreted or misdiagnosed as developmental delays, difficult temperament, or behavior problems. Because of the burgeoning knowledge about brain development and the immediate and long-term impact of trauma in early life, it is an important time for mental health professionals and those focusing on child development to be informed and trained in evidence-based treatments for young children impacted by trauma. Readers of this book will learn that early traumatic exposure can set a child on a path of developmental, behavioral, emotional and mental health challenges. These challenges can be addressed or moderated by appropriate interventions,

# Treating Infants and Young Children Impacted by Trauma

## Interventions That Promote Healthy Development



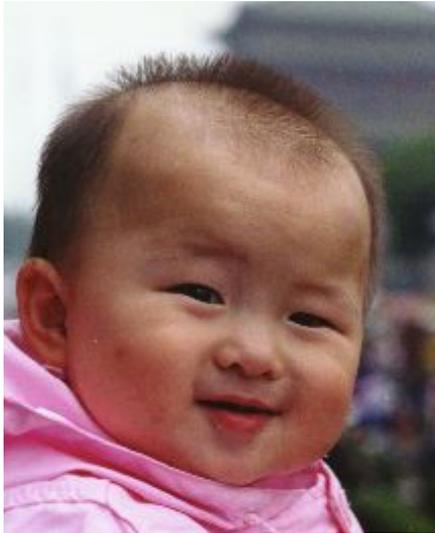
Joy D. Osofsky, Phillip T. Stepka, and Lucy S. King

support and treatment. My hope is that readers of this book will learn that the negative effects of exposure to trauma can be prevented and that developmental outcomes for children improved significantly with early implementation of evidence-based treatments.

[The book is available through the American Psychological Association](#)

and [at Amazon](#).

# The Affiliates Corner: Establishing a WAIMH Affiliate in China



## Introductory Remarks

In this salient reflection, Chinese colleagues describe their efforts to grow the field of infant mental health in China. The paradox of rapid economic growth alongside under-resourced mental health services is highlighted alongside the potential within China, due to its centralised government, to develop infant mental health oriented social policy. They also articulate the challenge to draw on knowledge from the western world while also being domestically innovative to ensure the best cultural fit for local programmes and initiatives.

As part of this work and to support their endeavours, our Chinese colleagues have been working to establish a WAIMH affiliate in China. To this end, they invited a WAIMH representative to their recent international forum organized through the Chinese Association for Maternal and Child Health Studies. Dr Watanabe, from Japan, represented WAIMH in this ongoing collaboration between WAIMH and the Chinese Association for Maternal and Child Health Studies.

– Maree Foley, Child, Family and Organisations Relational Health Consultant, Geneva, Switzerland

## Establishing the Chinese Affiliate of WAIMH—Current Development and Challenges

By Hongyan Guan, MD, Department of Early Childhood Development, Capital Institute of Pediatrics

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While maintaining the fastest growing economy in human history, as well as making significant improvements in population health, the People's Republic of China (China) has been falling behind in its mental health services. Infant Mental Health (IMH) is not a well understood term for most. In order to address this gap, we have been taking the first steps towards establishing a Chinese Affiliate of the World Association for Infant Mental Health (WAIMH). This short report summarises the work that has been carried out and future challenges for promoting infant mental health in China and for establishing a WAIMH Chinese Affiliate.

### Background

While the importance of Early Childhood Development (ECD) has been steadily gaining traction from both the public and central government of China, early ECD intervention programs currently focus primarily on nutrition, physical development (e.g., height and weight),

and disease control. The Yingyang-bao (Translation: nutrition pack) program for example, benefits approximately 1.4 million infants annually and costs \$75 million. However, significantly less attention is paid to family and infant mental health. At the same time the country's rapidly changing circumstances reflect developmental risks for young children and families.

Despite China's remarkable economic transformation, there is increasing economic inequality. China's Gini coefficient was 0.55 in 2012 (Xie & Zhou, 2014), significantly higher than the warning level of 0.4 set by the United Nations. Poverty in rural areas of China is particularly problematic as people move to urban areas to seek employment. China currently has an estimated 247 million people described as 'floating population', which translates to approximately 35.8 million migrant children (Yang D. 2016), and more than 9 million children being left-behind in rural areas (National Report of Left Behind Children, 2016).

However, as migrants do not qualify for full access to services and resources, including migrant children's opportunities for education, there is additional strain on children and families. Rural parents pressured to seek greater income far from home are confronted with the dilemma of having to either leave infants and young children with elderly relatives, which

has been associated with diminished developmental stimulation, or migrate with children in tow but risk limited access to education and forego the support of extra family caregivers. A cross-sectional survey conducted in one county with a high proportion of migrant population in Anhui province has showed that approximately 19% of infants are separated from their biological parents and receiving family care (not biological parents) by six months of age, while 45% of infants are in such care by one year of age (Guan, 2016).

Other threats to infant mental health are also significant. Such as the rising number of divorce and family fragmentation, highly pressured work for large proportion of parents in urban cities, and emphasis on material provision in parenting. Furthermore, infant abandonment remains high and Child Welfare Institutions are constrained in moving toward family-based placements. For example, the foster care policy-making that is not oriented toward infant mental health.

## New Development in Establishing the Chinese Affiliate of WAIMH

In this context, we began the process of establishing the Chinese Affiliate of WAIMH. Establishing any professional organisation in China requires governmental approval and the process can be long. Our aim was to incorporate WAIMH's aim and vision into a local organisation in order to:

- promote the concept of IMH among public, professionals, and governmental sectors;
- provide professional knowledge and training to health professionals in IMH within China; and
- organise forums, study groups, national/regional conferences, and collaborations between Chinese scholars and those from overseas institutions.

The Chinese Association for Maternal and Child Health Studies (CAMCHS) was established in 2012 as a government-recognized non-profit organization. Working within the restructured aims of the National Health and Family Planning Commission (NHFPC), CAMCHS regularly hosts ECD national round table meetings and international forums. It also organises government authorized training programs. After a year of discussions and meetings, CAMCHS decided to embed WAIMH's vision and mission into their existing ones, and work as the China affiliate for WAIMH.

Although details are yet to be discussed in terms of actions to take to integrate WAIMH and CAMCHS, in April this year, CAMCHS held an international ECD Conference, in Beijing. The conference was titled: "Promoting nurturing care for children 0-3 years". It aimed to introduce IMH to attendees. During this conference, Chinese government officials, including high level representatives from the National Working Committee for Women and Children under the State Council, and the National Health and Family Planning Commission, gathered with international experts from WHO, UNICEF, America, Australia, Mexico, Turkey, and Japan, as well as more than 400 clinicians from 29 provinces of the country. The two-day conference had 18 presentations. Topics covered included: (1) different intervention programs from USA, Australia, and Turkey; (2) research tools and guidance to measure and assess the impact of ECD interventions; (3) implications of responsive caregiving and high quality parent-child interaction; and (4) the importance of governance for multi sectoral collaboration, and ensuring

optimal ECD outcomes for children with special needs.

Dr Hisako Watanabe from the WAIMH board gave a keynote speech on the 2nd day, highlighting the importance of IMH among all domains of early development. She appreciated the enthusiasm of the participants, comprised of the Chinese government officials and local leaders across the country who gathered to promote early childhood development for the coming generations. She urged them to preserve the Chinese intuitive parenting which is a unique heritage of culture and tradition embedded in the non-verbal realm of unconscious in everyone born and bred in China. She also advised them to value their identity while absorbing modern technology and information. She drew on how Japan's rapid post-war industrialisation has yielded nationwide dysfunction of intuitive parenting and family life leading to ever-increasing emotional problems in children such as maltreatment, school refusal, social withdrawal, anorexia nervosa and others.

Dr Watanabe also held private meetings with CAMCHS head, as well as leaders from the National Working Committee for Women and Children, and discussed possible future events that might be helpful for establishing the Chinese Affiliate of WAIMH, as well as promoting infant and family well-being in China. She acknowledged the complexity of integrating western infant mental health into the unique asian social system of China. Dr Watanabe assured continuing support from WAIMH in the development of the Chinese Affiliate of WAIMH; a process which will be an exciting joint venture and reciprocally beneficial to Chinese professionals and to WAIMH.

### Future challenges

To ensure real change in promoting infant development in China, we not only need recognition of the importance of IMH but we also require concrete actions. There are three major challenges we aim to currently address. First, China lacks trained infant mental health professionals. Practitioners working on the front line in hospitals, community centres and schools know little about IMH and theories such as attachment theory. Good training under well-designed curricula will help build a strong work force to implement interventions in their daily practice. However, the government must provide regulations and serve as a gate-keeper for quality control, defining both trainer and practitioner qualifications to work in IMH. Second, politically, we also aim to

bring IMH into policy-making. China is a large country but one with significant central government capacity to ensure policy implementation. Last, in the field of IMH research, China requires well-trained scientists in theory and methodology to carry out high quality research projects. At the moment, most programs related to IMH and more broadly Early Childhood Development, are brought in from countries such as the USA and Australia. Innovative education programs for researchers and practitioners domestically will help the localisation of overseas programs, as well as designing our own.

After the government's endorsement of the two-child policy, the country is expecting 20 million live births in the year 2020. How to care for the most important resource for the country's future and how to raise competent and responsible generations, are issues that need urgent solutions to ensure optimal development for China's infants.

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# News from the WAIMH Central Office

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Dear colleagues and friends,

In this letter, we will introduce you to the Rome congress, the result of the election of a new WAIMH Board member (2018–2021), and the Sponsor a Delegate Programme for the next World Congress in Rome.

## Rome World Congress

The 16th WAIMH World Congress in Rome, Italy, is nearing with the central theme of “Nature – Nurture, challenges for the 3rd Millennium infant mental health”. The submission of abstracts has now closed. By the deadline, we received 992 single abstracts, including 361 abstracts for Brief Oral Presentations (BOP), 459 abstracts for posters, 151 abstracts for workshops, and 22 abstracts for video presentations.

In addition to single abstracts, we received 150 proposals for symposia. With the 992 single abstracts and the 1,086 symposium abstracts, we reached the highest number of submissions in the history of WAIMH World Congresses: a total of 2,078 abstracts! This is a wonderful result and means that we will have an extremely exciting congress with a multitude of presentations. We wish to thank all who are willing to share their clinical innovations and scientific results with others.

Based on the list of submissions under review, we can already tell you that the quality of both scientific and clinical presentations will be excellent. The submissions also cover a remarkable variety of themes, ranging from neuroimaging studies of the infant brain to 30-year follow-up studies, and innovative clinical interventions. The registration for the WAIMH 2018 Congress is open, and you can register with the early bird rate until February 28, 2018. We hope to see many of you next May in Rome, but if you

are unable to join us and enjoy Rome in person, the following website lists 10 films set in the beautiful city:

<https://theculturetrip.com/europe/italy/articles/10-films-that-will-make-you-fall-in-love-with-rome/>

## New Board member elected

As the year draws to a close, we wish to thank you for participating in the election of a WAIMH Board member for the term 2018–2021. We would like to thank especially the four candidates, Astrid Berg, Holly Brophy-Herb, Nicole Letourneau, and Julie Stone, for their dedication to promoting infant mental health across the world.

In total, 1,161 WAIMH members (2016 or 2017) were eligible to vote in the election that took place from November 15 to December 15, 2017. A member could vote for one candidate. A total of 239 members cast their vote. The voter turnout was at 20.6%. The results show that Astrid Berg was elected with 79 votes. Of the other candidates, Julie Stone received 75 votes, Nicole Letourneau 43 votes, and Holly Brophy-Herb 42 votes.

## The Sponsor a Delegate Programme

The majority of infants live in developing countries where clinicians and researchers have limited resources for sharing current knowledge and skills in the field of infant

mental health with colleagues from other countries. In order to be truly multinational and culturally diverse, WAIMH launched in 2012 a Sponsor a Delegate Programme for WAIMH World Congresses. The initiative came from Astrid Berg and her team, and the program was successfully implemented for the first time at the World Congress in Cape Town.

The current Sponsor a Delegate Programme for the Rome World Congress 2018 aims to offer more colleagues from developing countries a chance to participate in the Congress.

WAIMH is kindly asking individual Congress delegates, WAIMH members, other infant mental health professionals, Affiliate associations of WAIMH, and other associations or companies to donate money and thereby help colleagues from developing countries to participate in the 16th WAIMH World Congress in Rome, giving them the opportunity to share their own knowledge, to learn more about infant mental health and to meet colleagues working internationally in the field. The amount of money you wish to donate (minimum donation: EUR 20,00) can be paid online when registering for the Congress. For more information, please visit the [Congress website](#).

Last but not least, we at the WAIMH Central Office wish you all happy holidays and all the best for the New Year!



Picture from WAIMH World Congress in Prague (2016).