

Perspectives in Infant Mental Health

Professional Publication of the World Association for Infant Mental Health

Contents

From the Office of the WAIMH Executive Director,
K. Puura.....1

From the Editors,
D. Weatherston, M. Foley & H. Fitzgerald.....3

Integrating Infant Mental Health at Primary Health Care
Level,
K. Puura, E. Malek & A. Berg..... 4

Dr. Robert Emde presents the history and development of
WAIMH and the field of Infant Mental Health,
.....7

Roman Reflections WAIMH 2018.....8

WAIMH Honors Exceptional Members from Around
the World,..... 11

The Search for a new IMHJ Editor-in-Chief is underway,
..... 14

Public Policy and Infant Mental Health,
D. Weatherston & H. Fitzgerald15

Perspectives Outreach Calling all Infant Mental Health
Professionals!,.....18

INTRODUCTION TO “COULD OR SHOULD A ROBOT REAR A
BABY?”,
M. Foley.....19

Could or should a robot rear a baby?
C. Andries, B. Cowley, L. Nhlanhla, J. Noble, T.
Whittaker, E. Williams, B. Wirz, A. Lachman, A. Berg & L.
Richter.....19

Book review
The Emotional Life of the Toddler, Alicia F. Lieberman,
Simon & Schuster, 2018 (Revised and Updated Edition),
D. Weatherston.....24

From the Office of the WAIMH Executive Director



By Kaija Puura, MD
Tampere, Finland

Dear WAIMH members, colleagues and friends,

This is my first column in Perspectives as the Executive Director of WAIMH. The boots I stepped into from the first of August this year are very big and I do feel quite honored and a bit intimidated. My predecessors, Hiram Fitzgerald and Pälvi Kaukonen, each did a tremendous job as Executive Director. I will do my best to serve our organization with

similar dedication and skill. Luckily, I will not be alone, as I have Reija Latva as the new Associate Executive Director to work with and Minna Sorsa and Sari Miettinen who continue to work at the WAIMH Central Office. Pälvi has also kindly promised to act as our advisor as long as we need – special thanks to Pälvi!

Perhaps it would be in order to write a few sentences of who I am. In my everyday work I am professor of Child Psychiatry in the Tampere University and head of development and research projects in the Department of Child Psychiatry in the Tampere University Hospital. Our research groups have



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studied the effect of maternal depression on child development and shared pleasure in early parent-infant interaction. We have also been interested in helping primary care personnel to identify infants and families in distress. Through our studies we have developed two measures, the Infant Mental Health Assessment form and the Brief Infant Mental Health Screen (together with South African colleagues). Currently I am developing digitalized services for families with infants and young children, hoping to help particularly anxious and depressed parents easier and earlier.

The world we live in is going through rapid changes, and, at least for me, quite a lot of those changes bring about worries and anxieties. This year we had an exceptionally warm summer here in Finland, and, for the first time in my life, I did not feel happy about warm summer weather. There was no help for it: we all got to think and talk about the climate changes and global warming. Natural disasters like floods, draught, fires and storms seem to be more frequent than before, forcing people to leave their homes and live in uncertainty for shorter or longer whiles. These disasters affect infants as well.

I found myself thinking particularly of flying - and congresses - since I have been involved in organizing WAIMH World Congresses since 2006. Flying has been identified as one of the big polluters of the atmosphere, and people fly more on more every year. Should we as an organization also start thinking more about environmental aspects of our activities? Is it not part of infant mental health to try to ensure a healthy and safe

environment for our infants? At the same time as I feel worried and guilty about all the flights I have made and will make in the future, I also know that meeting people through video connections or having maybe your hologram appear in someone's room cannot feel the same as being with friends in face-to-face real life encounters. We need each other's company and hugs to do the work that we do on behalf of infants and families- no way we can achieve that in isolation or solely through technology.

As I was pondering this I also attended a scientific conference for Nordic child and adolescent psychiatrists in Turku, Finland, where one of the main presenters addressed this question. He told us that he had paid a little sum of money for protecting the environment in connection with buying his flight ticket. Should we start doing the same? Or might we include a voluntary fee for the environment and the protection of infants in the registration for our world congresses? I would be happy to learn what you think and feel about these issues.

Life is rich and complicated, as it always has. I do hope that we all can still remain optimistic about the future and keep up doing our important work for infants and families all around the world. I do hope each and every one of us has that one special friend, a "go to person," who will give us a hug when we sometimes feel hopeless or alone.

With my warmest regards to you all,

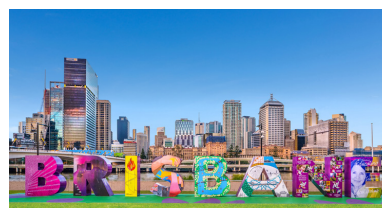
Kaija



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From the Editors



By Deborah J. Weatherston, Editor,
Michigan, USA, dweatherston@mi-aimh.org

Maree Foley, Associate Editor, Switzerland/
New Zealand, maree.foley@xtra.co.nz

This double issue continues the new format for WAIMH Perspectives in Infant Mental Health. With the use of Social Media, WAIMH Central Office staff posts each submission after it has been reviewed and accepted for circulation. Weekly or bi-weekly postings on the WAIMH Facebook page call attention to what members around the world are thinking, doing, and writing about. Because we also value tradition, we assemble the articles and, with the help of the Central Office staff, publish them in full issues of Perspectives. We welcome your comments and suggestions regarding this new format.

With his issue, we are pleased to introduce you to the new WAIMH Executive Director (ED), Kaija Puura, MD. Dr. Puura introduces herself to you in the first article of this issue. She brings strength, depth, commitment, and a wonderful sense of humor to the position. Wishing to shine a light on WAIMH members who received awards at the WAIMH Congress for exceptional service to infants, toddlers, and families, we highlight Antoine Guedeney (Rene Spitz Award), Pälvi Kaukonen (Sonya Bemporad Award), Lynn Priddis (WAIMH Award), and Elisabeth Conradt (WAIMH New Investigator Award). The 2018 WAIMH Congress was memorable; we offer reflections from members who travelled to Rome and were eager to share their experiences and offer appreciation to the

Italian Association for Infant Mental Health, the host committee and the WAIMH Board for planning the amazing global event.

Three papers are varied and of particular interest. The first is Integrating Infant Mental Health into Primary Care, written by colleagues Kaija Puura, Elmarie Malek, and Astrid Berg from Finland and South Africa who have developed and integrated a basic infant mental health screen for us in a maternal and child health screening tool. The second is Public Policy and Infant Mental Health, contributed by Hiram Fitzgerald and Deborah Weatherston from Michigan, which expands on the WAIMH Policy Symposium at the WAIMH Congress presenting the thinking of participants Jane Barlow (UK), Catarina Furmark (Sweden and Nordic countries), Catherine Maguire (Ireland), and David Willis (US). This paper invites consideration of policies and gaps in policies specific to the well-being of babies and families in many parts of the world. Graduate students enrolled in a new graduate Master's of Philosophy in Infant Mental Health, developed and directed by Astrid Berg at Stellenbosch University in South Africa, contribute a third paper, Could or Should a Robot Rear a Baby? As part of the new programme, guest professor, Linda Richter (Witwatersrand University, Johannesburg, South Africa), invited the students to apply what they were learning about infant mental health to the rapidly developing field of artificial intelligence. This paper reflects their response to the provocative question.

These articles are followed by a review of Alicia Lieberman's book, *The Emotional Life of the Toddler*; the announcement

of a search for a new editor of the *Infant Mental Health Journal*; and, recognition of Bob Emde and his historical perspective on WAIMH and the infant mental health community recorded on YouTube.

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

Integrating Infant Mental Health at Primary Health Care Level

By

Kaija Puura, University of Tampere, Finland

Elmarie Malek, Stellenbosch University, South Africa

Astrid Berg, University of Cape Town, South Africa

The Context

Since the advent of democracy in South Africa considerable advances have been made in health care delivery. Financial and human resources that were previously concentrated in tertiary, academic sections have been channeled into primary health care setting and in this way have enabled an almost universal access to basic health care.

The Western Cape is one of South Africa's nine provinces with a population of over six million people with over half a million being under the age of 4 years.¹ Every mother and infant are recorded on a central system and receive documentation on the birth of the child. These documents that are currently under review, provide an opportunity to track the infant's development from a holistic perspective.

Traditional screening tools have focused almost exclusively on physical development. Physical growth is an accepted indicator of child health status and this is inevitably linked to caloric intake; the weighing of infants is thus part of the well-baby clinic visits. However, in addition to nutrition received or the lack thereof, it is known that maternal depressive symptoms are associated with a 40-50% higher estimated risk for faltering weight (Surkan et al, 2016). This finding was highlighted in a clinical survey of the University of Cape Town Parent-Infant Mental Health Service (Berg, 2012) and supported the notion that more than food is needed for adequate growth.

In addition to the mental health aspects as they relate to faltering weight, there is a general and growing appreciation of the importance of the beginnings of life. Neuroscience has demonstrated the rapid growth of brain structure and function in infancy, making this time the most plastic period of human development (Gao et al,

2016). The counter-point of plasticity is susceptibility. The problems our society and many other societies are facing such as the high rate of crime, substance abuse, and domestic violence can be traced back to adverse early experiences. It thus became imperative for the authorities in the health sector to acknowledge that the vision of "Quality Health for All" starts at the very beginning of life, not only from a physical, but also from mental health point of view.

In parallel to these developments there occurred a conceptual shift on Governmental level to move "from managing the consequences of the burden of disease to improving wellness"; this shift mirrored current trends in the mental health field as reflected in the burgeoning of interest in the promotion of a healthy start to life. Paying attention to infants and young children and to their primary relationships is possibly the most important 'upstream factor' that impacts on health and mental wellness in the whole of society.

The Parent Infant Child Health and Wellness Working Group

It was within this context that a multi-disciplinary working group – The Parent Infant Child Health and Wellness Working Group (PICH WG) was established in 2013. It was mandated to drive the agenda for the Western Cape Provincial First 1000 Days Initiative which is a lead project of the Provincial Strategic Plan for 2014-2019, under the Provincial Strategic Goal 3 Increase wellness and safety and tackle social ills.

The Working Group has two main aims:

1. To unify various sectors of administration, such as the Departments of Health, of Social Development, of Education, and others, such as the Department of Arts and Culture. The Group is raising awareness within these departments of the importance of the First 1000 Days (that is, from conception to age 2 years); and
2. To supply scientific evidence that demonstrates that there are economic benefits to investing early in the life span.

Unifying various sectors of the administrations will enable a broad based inclusive message about the importance of the beginning of life to be delivered to all population groups. Besides the endeavor to work together across systems, there is the challenge of delivering the message in a manner that is respectful of cultural diversity. It is in this nuance that true transformation is manifest.

Within the Department of Health, awareness of the importance of the First 1000 Days has led to a better understanding of the need for providing comprehensive services during pregnancy inclusive of maternal mental health and psychosocial support services as well as providing support for parental readiness and recognizing the important role of fathers – key domains for fostering parent-infant attachment starting early during the prenatal foetal/infant developmental stage. The First 1000 Days has thus provided a natural umbrella to also unify previously siloed departments also within the Health Department. Beyond this, it has brought home the recognition amongst health workers that an empathetic approach is essential in working with pregnant mothers, given a better understanding of the contextual factors surrounding the pregnant mother that in turn impact on the developing infant both pre- and postnatally.

In South Africa, the National Road to Health Book is issued at birth to all infants. It is a patient held record which records essential basic health information about the baby, including birth, immunization and Vitamin A, growth parameters, development, oral health, and hospital admissions. It also contains age-group related feeding recommendations and play and stimulation messages. A complementary tool has recently been developed called the postnatal checklist tool to assist with implementation of a Western Cape Postnatal Care Policy, which provides guidance for care of mothers and infants in the first 6 weeks after birth of the baby. A copy of this tool is added to the Road to Health Book after birth. The Postnatal checklist has two components, one for the mother and one for infant and both are completed at various set time points during this 6 - week period. The 5 questions from the Basic Infant Mental Health Screen (BIMHS), as described further below, have been incorporated into

¹ <http://www.statssa.gov.za/publications/P0302/P03022014.pdf>

the Post Natal Care tool (in partnership with Edna Arends, Western Cape Provincial Maternal and Newborn Health Program). A training guide for staff on the background to these questions and guidance on their implementation is being developed.

These tools will include a checklist with key questions and will be complemented with more detailed parental questions and guidance. Care has been taken to align these processes to a broader initiative to develop comprehensive paediatric clinical guidelines for primary health care clinical practitioners (Practical Approach to Care Kit (PACK-Child), Knowledge and Translation Unit, University of Cape Town), which has included the infant attachment screening questions as well as guidance on parenting information.

The additional questions are the result of a collaboration with colleagues in Finland where infant mental health has been integrated into primary care. The background to each requires further elaboration.

The Basic Infant Mental Health Screen incorporated into the Maternal & Child Health Risk Screening Tool

Screening infants for signs of somatic illnesses has been established as a part of primary health care in many countries and has been shown to be an effective way for improving health of infants and young children (e.g. Köhler 1991). Awareness of the importance of mental health early in life has been steadily increasing ever since 1970s, and tools for detecting psychological distress in infants and young children have been developed as a consequence (e.g. Guedeney, Puura and Matthey 2013). Finland is one of the Nordic countries with a well-baby clinic network that has long been developing strategies and tools for screening for both physical and mental health for infant and young children, and also studied the feasibility of screening in primary health care (Puura et al. 2010, Kaukonen et al. 2010, Borg et al. 2014). Based on findings of earlier studies, The Basic Infant Mental Health Screen (BIMHS) was developed as a joint effort of Drs. Kaija Puura, Astrid Berg, Elmarie Malek and Pålvi Kaukonen. It is a simple and short tool to be used to screen for the basic markers of infant mental health globally, as the items most likely are not affected by cultural differences, at least not during the first year of life.

The first two items are simple questions of whether the parent is worried about the



In the waiting room. Photo published with courtesy of Astrid Berg.

child and how the parent is feeling herself/himself. The question about parental worry was derived from a previous study, where the question: "Overall, do you think that your child/this child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people" alone was found to be quite reliable as a screening question for developmental or psychological problems in young children in a survey done in primary health care in Finland (Borg et al. 2014). For the BIMHS the question was rewritten to "Are you worried about your infant/child?" and with a positive answer from a parent, further questions are to be used to clarify what sort of worry the parent has.

Parental mental health problems like anxiety and depression, have been associated with poorer parent-infant interaction and infant distress in several studies (e.g. Mäntymaa et al. 2008, Luoma et al. 2013). The second question of the BIMHS comes from a study by Puura et al. (2010) where infants aged 4, 8 and 18-months of age were screened in primary health care for infant social withdrawal symptoms. In this study, a question "How has your mental health been during the past 12 months?" was quite reliable in finding parents who had not been well psychologically, and whose infants showed symptoms of infant social withdrawal (Mäntymaa et al. 2008). For the BIMHS the question was reformulated into "How have you been feeling?" to help tap any symptoms of anxiety, depression or other mental health issues. It is also a way to show the parent that the primary care worker is interested in the parent's well-being.

The third item on the BIMHS is weighing and measuring the child for two reasons: abnormalities in weight and height can be markers of malnutrition or somatic illnesses, but growth can also be slowed as a result of psychological distress (e.g. Patel et al. 2004, Walker et al. 2007). The two further items: infant's eye contact with the parent and the health care worker and the shared pleasure between the infant and the parents are markers of both parent-infant interaction and infant social behavior. Eye contact between an infant and the parent or examiner has been previously connected with good-enough early interaction and healthy infant development in studies from several countries (Matthey et al. 2005, Dollberg et al. 2006, Lopes, Ricas and Mancini 2008, Puura et al. 2010; Puura et al. 2013).

Shared pleasure as defined by eye contact and simultaneous smile or laughter between a parent and an infant has in recent studies been found to be associated with good parent-infant interaction and less emotional problems in early childhood in samples from Finland and South-Africa (Mäntymaa et al. 2015, Lachman et al. 2016, Puura et al. in press). The final item about the possible worry of the primary health care worker was also found to be a good predictor of possible problems of young children in the study of Borg et al. (2014) and was therefore included into the BIMHS.

For each item of the BIMHS we created some additional questions to be asked, should the parent tell about problems or should the primary care worker detect a problem in the growth or social behavior of the child. These questions were meant

to help further discussion on the possible problem and can be modified and added to. As we wanted the BIMHS also to offer help for the primary care workers in what do with the possible problems, Drs Berg and Malek also created action guidelines. These guidelines naturally can and must be adjusted according to the possibilities and services available in different sites. Prior to this project, the BIMHS has not been in clinical use, but it has been mentioned as an example in an article meant for general practitioners on what to pay attention to when screening for mental health problems of young infants and their parents (Puura and Tamminen, 2016).

Challenges

Incorporating a new element into existing protocols is often met with resistance. This is in large part due to a heavy patient load in the primary health care setting, understaffing and thus not sufficient time or motivation to enquire about mental health problems. In addition, nurses and community health counsellors often feel ill-equipped to deal with the problems that might become evident. To address these challenges, we suggest a three-pronged approach.

First, by shortening and simplifying the questions it is hoped that they will be easier to ask and by inserting them within the general health checklist or screening tool, they will become part of a holistic approach, so that mental health may be seen as part of general health.

Second, a training guide will be developed in order to explain the reason for asking these questions and also to provide prompts to follow should an answer require more in-depth exploration. It is hoped that this will empower the health workers and increase their confidence in asking the additional questions.

Third, the next step would be to identify the resources in the community that provide health care, such as NGOs of which there are a great number, but each working in parallel and often in isolation. There is a surprising level of activity on the ground that has not been noted by academic institutions and government structures. These organizations need to be identified, described, and then mapped, so that the community health worker has service providers at hand to which parents and infants can be referred to receive help.

Given the above three approaches, it is hoped that some of the challenges will be overcome.

Acknowledgements

We thank Edna Arends, Assistant Director, Western Cape Provincial Health Maternal and Newborn Health Program and Dr Janet Giddy, Khayelitsha and Eastern Substructure Maternal and Child Health Program for their collaboration and support in the integration of these screening questions into the development and implementation of new tools. Without their contribution the acceptability and feasibility of using these questions would never be known.

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Dr. Robert Emde presents the history and development of WAIMH and the field of Infant Mental Health

Emeritus Professor of Psychiatry, Robert Emde, presented the history and development of the field of Infant Mental Health in a plenary lecture at the 15th World Congress of WAIMH in Prague in 2016. He introduced his talk with the title: "Infant Psychiatry and the origins of WAIMH -Early Contributions that Energized the Field."

In his remarks, Dr. Emde presented the history of the field of infant mental health, including early pioneers such as René Spitz, Selma Fraiberg, and T. Berry Brazelton. He talked about the science of early relationships and its relevance to early mental health, as well as the role the infant plays in effective clinical practice.

The presentation is published in the WAIMH Youtube channel and lasts for 1 hour 7 minutes. The video concludes with a period of discussion. Dr. Emde is introduced by WAIMH Affiliate Council Chair, Maree Foley.

Robert Emde is the Honorary President of World Association for Infant Mental Health. He is one of the most influential architects of Infant Mental Health, believing in the power of relationships to effect change and the impact of relationship on relationship, concepts of particular meaning within the infant mental health community. He is a prolific writer, having published over 300 scholarly articles read by infant mental health practitioners across the world.



Watch the video on You Tube:

<https://www.youtube.com/watch?v=AEeQYPGG9VE>

Previous articles in Perspectives (Linked to past text in Perspectives):

Bob Emde as a Plenary Speaker at 15th World Congress of WAIMH

<https://perspectives.waimh.org/2015/12/15/bob-emde-plenary-speaker-15th-world-congress-waimh/>

Robert N. Emde, Honorary President. By the Red Cedar column. By Hiram Fitzgerald.

<https://perspectives.waimh.org/2007/06/15/robert-n-emde-honorary-president-by-the-red-cedar-column/>

A Tribute to Kathryn Barnard and Peter de Chateau. By Hiram Fitzgerald.

<https://perspectives.waimh.org/2015/12/15/tribute-kathryn-barnard-peter-de-chateau/>

Roman Reflections WAIMH 2018

Many members from around the world send their thanks to WAIMH and the Local Organizing Committee for planning and hosting an extraordinary WAIMH Conference. From the reflections received below, it was personally and professionally a very successful and meaningful experience for research faculty, policy makers, and practitioners from many corners of the globe. We send our deepest and collective appreciation for an exceptional world conference and Roman holiday!

Jody Todd Manly, Ph.D., WAIMH Board of Directors

Clinical Director

Mt. Hope Family Center

Rochester, NY

I would like to express my appreciation to the Italian Association for Infant Mental Health (AISMI) organizing committee and the WAIMH staff and Program Committee for putting together an intellectually stimulating and productive 16th World Congress in Rome. AISMI gave a warm welcome to 1750 delegates from 72 countries who delighted in hearing the children from Schola Cantorum sing in the opening ceremony. Their final gospel song in English got such a rousing response, they repeated it for an encore!

With such a large number of presentations, plenaries, master classes, posters, and meetings, it was difficult to choose what to attend, and I often wished I could have fit more in my schedule. I enjoyed learning so much in the sessions I attended on prenatal development, digital media, epigenetics, internal representations, therapeutic interventions, public policy, and parent-child relationships. I enjoyed presenting with my colleagues, Alicia Lieberman and Sheree Toth, on Child-Parent Psychotherapy.

But the most encouraging part of the Congress was joining together with so many people from around the world who persevere in difficult circumstances to shed light on the challenges faced by young children and their families and who will not stop until we have supported these



vulnerable world citizens and promoted a more positive world in which they can grow and develop. Erum Mariam brought me to tears as she shared her experiences in the refugee camps in Bangladesh. I continue to be awed and inspired as I hear of the outstanding work that is being done around the world to combat tragedy and promote healing.

Joining together and building our own relationships gives me hope that together we can make a difference and truly make the world a better place! As the Congress drew to a close, the Australian Association for Infant Mental Health took the torch and invited everyone to the 2020 Congress in Brisbane. I am looking forward to reuniting with an amazing group of international colleagues in two years.

Margaret C. Holmberg, Ph.D. IMH-E®

President, Alliance for the Advancement of Infant Mental Health

Connecticut Association for IMH, Board Member

WAIMH was an energizing experience, connecting with friends met at previous Congresses, meeting new colleagues, and hearing messages from those committed to making the world safer and more emotionally safe for infants and young children. Congratulations and thank you to all who made the 2018 Congress such a meaningful event.

Karol Wilson, LMSW, IMH-E®

Infant Mental Health Mentor, Trainer, and Reflective Supervisor

Starfish Agency, Detroit, Michigan

It was an honor and a privilege to attend the 16th World Congress for Infant Mental Health in Rome. The opportunity to listen and witness the research, clinical interventions and cross-cultural studies that held varying perspectives of caregiving practices and socio-emotional health was an amazing gift.

To hear our Infant Mental Health Leaders and Mentors talk about the impact of trauma and separation on families and young children, both nationally and internationally, was powerful and reignited my passion and commitment to our most vulnerable citizens. The conference was a reminder that we cannot do this work alone and that we are not alone. There are 100's of thousands of voices speaking out on behalf of infants and young children. I was proud to be one of the many voices in Rome along with many of my Michigan colleagues who were well represented at the conference. Thank you for this incredible opportunity to learn and grow.

Astrid Berg, MD

WAIMH Board Member and Emerita
Professor University of Cape Town

Cape Town, South Africa

The 16th WAIMH World Congress was held in Rome at the end of May 2018. True to Roman tradition, it was a big event – possibly the biggest WAIMH Congress with participants from many countries having found their way to the Eternal City.

The choice of papers was wide and large – for some it was overwhelming, for others it felt like a rich menu from which to choose. WAIMH faces a challenge in that a balance needs to be found between offering an international platform to colleagues from all over the world, while preserving the ‘soul’ of WAIMH. What is this ‘soul’? It has to do with getting to know people, with a lively exchange, with time for discussing ideas and for sharing experiences. This is somewhat impeded by too large a gathering and with too many happenings. At the same time, this largeness also attests to the enthusiasm that is evident from all corners of the globe – the enthusiasm for speaking up for those too young to have the words to do so.

Of particular relevance was the Presidential Symposium held on the last day of the Conference. The focus on the worldwide refugee crisis and its effect on infant mental health was of critical importance given the catastrophes that are facing families in the world today. Erum Mariam spoke with urgency of the refugee camp in which she is working in Bangladesh, leaving us with images and stories of unimaginable suffering. It was a call to action – action for infants and young children – that we as WAIMH dare not ignore.

On a lighter note, there was true Italian passion in the air at the gala dinner when the four sopranos transported us with their elegance and beautiful voices to the world of the Opera. Rome is big and very old, fascinating in its ordered chaos. It was with sadness that we said goodbye to this City.

Angela Tomlin, PhD, HSPP, IMH-E®

Professor of Clinical Pediatrics

Indiana University School of Medicine

Indiana

WAIMH is such a unique experience due to the wide range of ideas that are shared from research, clinical, and advocacy viewpoints and from just about every cultural experience. But what I would like to highlight about my experience are the lovely chance conversations that I had with people from all around the world. An example that stands out: I was at the



poster session and started chatting with a presenter. We had a productive dialogue about her research and then we discovered some similarities in our experiences with our administrators, grandmothers and gardeners! What a hopeful moment for me, coming from a context in the States that

is much too often about “us and them” at this point in history. It felt great to have these points of alignment not just about our shared work, but also about our shared experiences as human beings.

Campbell Paul, MD

WAIMH Board Member and Associate Professor

Melbourne Australia

What an amazing Congress we have just experienced! Immeasurable thanks go to Giampaolo Nicolais, Massimo Ammantini and the Italian Local Organising Committee for providing such a creative fabric within which

the rich content of the scientific program was delivered by colleagues from all over the world and thanks also to the Scientific Program Committee and the overall Congress organizers. For me the Congress provided an opportunity to learn so much about very vulnerable infants and their families and about the plethora of ways that our colleagues in infant mental health are able to assess and so thoughtfully intervene.

It began with the pre-Congress sessions which focused on innovative research and applications and with the importance of training supported by our Affiliate organisation colleagues. Each of the plenary sessions took us in different directions, but all building a deeper understanding of the modern world of babies and their families. In each of the oral and poster presentations which I observed I saw a generous sharing of ideas and their clinical application. I feel very proud to be a member of the WAIMH community.

The Presidential plenary session, however, reinforced for me the importance of advocating powerfully for infants in families who are persecuted and displaced. Although there is so much inhumanity in the world which is difficult to comprehend, I believe that a powerful spirit of working together to a common goal was demonstrated moment to moment amongst the 1700 participants in the Congress! I really look forward to applying what I've learned at this Roman Congress and to meeting again at the next Congress in Brisbane 2020.



Ashley McCormick, LMSW, IMH-E®

Endorsement & Communications Coordinator

Alliance for the Advancement of Infant Mental Health

Michigan

A month after the event, I find myself still in awe of the experience of attending the WAIMH Congress in Rome. The future of the field of infant mental health felt limitless as I sat in the plenary room with 1,750 other individuals. I could feel, hear, and see the energy, passion and dedication we had in common. Thank-you to the WAIMH staff and Congress planning committee for providing us the space to be inspired!

Lindsay Biggs, LMSW

IMH Supervisor, Starfish Agency, Michigan

Coming to WAIMH and having the opportunity to hear about the work being done around the world on behalf of infants and toddlers was so inspiring. In a time when things often feel hopeless or overwhelming, it was an incredible reminder that we are not alone. There is a brave army of professionals out there with so much compassion, love and positive energy fighting on behalf of all babies, toddlers and their families. A strong group of people who all understand the power of relationships, ready to change the world. The whole experience was refueling so that I could come back and continue the most important work there is.

Maree Foley Ph.D., WAIMH Affiliate
Council Chair

Practice consultant

Geneva, Switzerland

The 16th WAIMH World Congress in Rome was a wonderful Congress. I am thankful to the Italian Association for Infant Mental Health (AISMI), to Giampaolo Nicolais, Massimo Ammantini and everybody on the Italian Local Organising Committee; to the Scientific Program Committee; our WAIMH staff; and the Professional Conference Organisers, for their generosity and work. Collectively they co-created an extraordinary base from which delegates could continue to explore and learn about our shared, complex, and interdisciplinary field.

Amidst the daily feast of plenaries, posters, workshops, symposiums and master classes, there were numerous memorable moments of marvelousness: from the delightful children's choir from the Schola Cantorum, in the opening ceremony; to the amazing opera divas during the conference dinner; to listening to fresh energetic new graduates; to sharing time and experiences with WAIMH affiliate council members; and being moved and heartened by the narratives of colleagues who are working with families with infants in day-in and day-out extraordinary challenging conditions and yet, amidst the despair, beckoned us to keep hope on our radar. Hope rooted in deep connection with those who suffer has the capacity to create momentum with healing and change, keeping paralysis and helplessness at bay.

Experiences of face-to-face time with old friends and new friends are now embedded as nourishing memories; as new fuel to sustain our ongoing work together, across the globe. At the end of the congress, the Australian Association for Infant Mental Health invited us all to the 2020 Congress in Brisbane. I very much look forward to meeting many of you again at the next WAIMH Congress in Brisbane 2020.

WAIMH Honors Exceptional Members from Around the World

Every two years, WAIMH honors members around the world for exceptional contributions to the field of Infant Mental Health. Please join the WAIMH Board in celebrating each 2018 WAI honoree for commitment to broadening our understanding of infancy and early relationship development through scientific research, policy, and practice. (<https://www.waimh.org/i4a/pages/index.cfm?pageid=3280>)

Antoine Guedeney, MD (Paris, France) received the Rene Spitz Award in recognition of significant lifetime contributions to clinical practice and research studies of benefit to the infant mental health community.

It is a pleasure to recognize Professor Antoine Guedeney M.D. with the 2018 Rene Spitz Award for lifetime contributions to infant mental health. Among his innovative and leadership contributions are the following:

His preventive interventions for infant mental health, including the large home visiting study in Paris for vulnerable families known as the CAPEDN study, that continues interdisciplinary research for health promotion as well as prevention of psychopathology. His effective advocacy for implementation trials in other risk communities of poverty, with needs occasioned by trauma and adversity.

His assessments of relational social withdrawal in infancy (also known as ADBB). These assessments are used in multiple pediatric, child psychiatric and service settings- and cross culturally validated in multiple countries, with longitudinal studies.

His clinical leadership, with contributions to meaningful diagnostic classification for infants and toddlers, wherein he has conducted clinical trials and worked to revise and update useful systems, being a leader in the revision known DC:0-3 R, that in turn provided a basis for our current system now known as DC: 0-5.



His editorial leadership in infant mental health, serving as inaugural and continuing innovative editor of *Devenir*, and then also serving as an associate editor of the *Infant Mental Health Journal*.

His collaborative research leadership over his career involving attention to multiple levels of biological and psycho-social models of development, and to integrative theories of change for intervention research.

His educational leadership regarding the importance of ethnic and cultural diversity and inclusion in communities of need—for infants and families not only in Western industrialized countries, but those elsewhere, in Africa as well as underserved countries world-wide. In this area we include his effective work within our organization, including as President of WAIMH and beyond.

Päivi Kaukonen, MD (Tampere, Finland) received the Sonya Bemporad Award in recognition of her significant contributions to the advancement of social and public policies that benefit infants, toddlers, and their families.

Dr. Päivi Kaukonen has been for decades a chief physician in the Department of Child Psychiatry at Tampere University Hospital, Finland. Her professional activities as a clinical child psychiatrist have involved: developing child mental health assessment methods, combining research activities with child mental health service development, and clinical work in primary care and mental health services. Since 2014 she has also worked as a Consulting Officer of Health Affairs in the Finnish Ministry of Social Affairs and Health, where her role and impact in leading the national reform of child and family health care and social services has been hugely important.

Päivi was in a crucial role in organizing the WAIMH Tampere Congress already in 1996, and after the Congress she became one of the founding Board Members of the Finnish Association for Infant Mental Health in 1997. When the WAIMH Central Office moved to Tampere, Finland in 2006, Päivi was appointed as the Associate Executive Director of the WAIMH, and then as the Executive Director in 2008. Since then Päivi has worked in efficient and extremely successful manner in organizing 5 WAIMH World Congresses around the world with financially favorable outcomes. In addition to this, Päivi has lead and developed the work at the WAIMH Central Office to include the WAIMH Affiliates and members around the world in a more continuous dialogue.

The Sonya Bemporad Award is presented to Dr Päivi Kaukonen for her undeniable merits in the development of clinical services for infants, and their families and for changing the whole Finnish society to a more infant friendly direction, and especially for being the heart and the soul of our organization.



Lynn Priddis, PhD (Perth, Australia) received the WAIMH Award in recognition of her significant contributions to the Australian WAIMH Affiliate and infant mental health practice.

Associate Professor Lynn Priddis is currently the Coordinator of the Clinical Psychology Program, and Coordinator of the Infant Mental Health Course, in the School of Arts and Humanities at Edith Cowan University, Perth, Australia. She has promoted infant mental health through her governance roles at regional and national level in Australia, and through research and training, especially infant mental health capacity building programmes in Western Australia. Lynn has been lecturing at Edith Cowan University in Perth since 1991 and has made a substantial contribution to the dissemination of scientific knowledge in the field of infant mental health.

In addition to her 37 peer reviewed journal articles, she has also been an innovative practitioner researcher as evidenced by the development of the Tuned-In Parent Rating Scales (TIP-RS); a tool for intervention with targeted parent-child relationships. Lynn has also been directly engaged with infant mental health competency based workforce development and training. She and her team designed a systems change model designed to infuse the infant relationship based model into all components of the Western Australia system of care, and then to track cross unit referrals for evidence that the system of care actually functioned as a collaborative network in support of a family. This community oriented work has been conducted via international



cooperation of colleagues across a number of WAIMH affiliates. Lynn Priddis has been active in Australian WAIMH affiliate and is Member of the leadership team within The Australian Association for Infant Mental Health.

The WAIMH Award is presented to Dr. Lynn Priddis for her continuing efforts to promote infant mental health programs and practices and for her clinically oriented research.



Elisabeth Conradt, PhD (Utah, USA) received the WAIMH New Investigator Award as a very promising new investigator.

Elisabeth Conradt received her PhD in clinical psychology in 2011 from the University of Oregon, where she studied the psychobiological correlates of early exposure to maternal insensitivity among a group of infants raised in poverty. Her post-doctoral training at Brown University examined risk and protective factors for the development of young children exposed prenatally to opioids and other substances. Elisabeth is now an assistant professor of developmental psychology at the University of Utah, funded by two grants from

the NIH to examine the epigenetic processes involved in the development of infant stress reactivity and regulation. In her work she tries to understand how early experiences become biologically embedded to impact neural, physiological, genetic, and behavioral outcomes.

Already at this early stage of her career, Dr. Conradt has a very impressive publication record with papers in highly competitive journals such as *Child Development*, *Development and Psychopathology*, and *Psychophysiology*, among others. She is already acknowledged as an expert in the field of behavioral epigenetics: She published an invited review paper on this topic in *Child Development Perspectives*, and was invited to submit papers to special issues devoted to epigenetics in top-tiered journals. Her outstanding achievements have already been acknowledged by early career awards from the Society for Research in Child

Development, the American Psychological Society, and the International Society for Developmental Psychobiology. Elisabeth sees great importance in wide dissemination of her research findings as evidenced by her presentations in various applied and clinical forums such as home visiting programs and a mindfulness-based intervention program for pregnant women who are addicted to opioids. She is deeply passionate about supporting the mental health needs of young children and their families, particularly infants exposed to substances in utero and those living in poverty.



The Search for a new IMHJ Editor-in-Chief is underway

INFANT MENTAL
HEALTH JOURNAL



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The Michigan Association for Infant Mental Health (MI-AIMH) and the World Association for Infant Mental Health (WAIMH) wish to express their deepest appreciation for Paul Spicer's work as Editor-in-Chief of the Infant Mental Health Journal (IMHJ). Paul has been an exceptional editor, broadening the reach of scientific contributions to the IMHJ and strengthening the depth of articles as they apply in meaningful ways to interdisciplinary practice. Paul will continue as the Editor-in-Chief through Volume 40, with the new editor joining him in July of 2019, and assuming responsibility for Volume 41 in October of 2019.

Sheryl Goldberg, Executive Director of MI-AIMH, owner of the IMHJ, has asked Nichole Paradis, a MI-AIMH member, WAIMH member, and Executive Director of the Alliance for the Advancement of Infant Mental Health®, to serve as Chairperson of the Search Committee. The Search Committee is composed of past editors of the IMHJ, representatives from MI-AIMH and representatives from WAIMH.

The position of Editor-in-Chief of the IMHJ requires:

1. A broad and strong interdisciplinary knowledge base from which to understand research, policy, clinical work, and practice in the field of infant mental health

2. Capacity to enter into and sustain working relationships with professionals including academics, researchers, clinicians, interventionists and others representing the infant mental health community across disciplines and around the world
3. Capacity to build and sustain an interdisciplinary editorial team with representation across the world
4. Understanding of editorial tasks including ability to make decisions about papers to be reviewed, knowledge with the editorial team of appropriate reviewers, organizational skills to handle submissions efficiently, confidence to expect reviewers to submit reviews in a timely manner, ability to make clear decisions about papers to accept, revise, or reject, ability to work with an interdisciplinary editorial board, and creativity to plan and solicit special issues to move the field of infant mental health forward in new directions
5. A 5-year commitment, beginning October 1 of 2019-September 30 of 2024.

Note: The Editor-in-Chief will receive a stipend for the editorial office.

The APPLICATION DEADLINE is December 15, 2018

THE DECISION WILL BE MADE BY April 1, 2019

The NEW EDITOR WILL BEGIN July 1, 2019 AND WORK COLLABORATIVELY WITH THE CURRENT EDITOR UNTIL OCTOBER 1, 2019

Please address any questions you have regarding the position or the application process to the Chair of the Search Committee, Nichole Paradis at:

nparadis@allianceaimh.org

If you are interested in applying for the position of Editor-in-Chief of the Infant Mental Health Journal, please submit the following information by e-mail to Nichole Paradis, Chair of the IMHJ Search Committee, nparadis@allianceaimh.org:

1. Letter expressing your interest in the position, relevant experiences, qualifications for the position, and vision for future for growth and development of the IMHJ
2. Your vita/resume, with contact information including mailing address, e-mail address(es), phone number, and fax
3. Contact information for 2 people familiar with your work

Public Policy and Infant Mental Health

By

Deborah J. Weatherston, Ph.D.

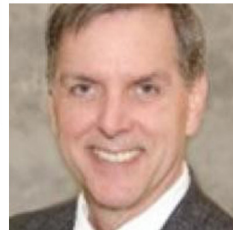
Alliance for the Advancement for
Infant Mental Health, Unites States

and

Hiram E. Fitzgerald, Ph.D.

Department of Psychology

Michigan State University, United
States



Based on comments presented during a Symposium on Public Policy and Infant Mental Health the biennial meeting of the World Association for Infant Mental Health. Health (H. E. Fitzgerald & D. Weatherston, Co- Chairs), May 2018, Rome, Italy.

Panel participants, J. Barlow, C. Furmark, C. Maguire, & D. Willis

In 2016, the World Association for Infant Mental Health (WAIMH) adopted its first formal public policy statement, drawing attention to issues specific to the rights of infants (WAIMH, 2016). The writers intended the document to serve as a stand-alone statement on behalf of infants, and a supplement to the United Nations' Convention on the Rights of the Child, which itself was a special addition to the Universal Declaration of Human Rights. In the words of the WAIMH Board of Directors,

...specifying the unique needs and rights of the child in the first years of life was needed in order to motivate infant oriented actions and policies at both community and societal levels.....many societies around the globe still pay insufficient attention to infants especially in times of stress and trauma. Additionally, consideration of infants' needs and rights could guide public policies and supports for mothers, fathers, and caregivers, and in giving value to babies in contexts of risk and violence...

The policy brief drew attention to three critical principles in the Rights document:

1. Principle 3: The infant's status as a person is to include equal value for life regardless of gender or any individual characteristics such as those of disability.
2. Principle 4. The infant has the right to be given nurturance that includes love, physical and emotional safety, adequate nutrition and sleep, in order to promote normal development.
3. Principle 5. The infant has the right to be protected from neglect, physical, sexual, and emotional abuse, including infant trafficking.

The Rights of Infants document was followed by a WAIMH Task Force, chaired by Karlen Lyons-Ruth. The Task Force report detailed the pervasiveness of emotional stress to which infants and very young children are exposed due to a wide number of adverse childhood experiences, including poverty, exposure to violence and war, poor health support, troubled parents, racism and poor supplemental child care (Lyons-Ruth, et al, 2017) . Indeed, the WAIMH's recent publication "Declaration of Infants' Rights" is an intentional effort to provide coherence for the extraordinary variation among countries with respect to issues promoting healthy social-emotional development during the earliest years of development. Despite 50 years of intense research on infants and very young children, relatively, we know relatively little about their racial, ethnic, and cultural diversity. This is of concern because more than half of the world's very

young children do not live in European or North American, predominately White, countries (Fitzgerald, et al., 1999; Fitzgerald, Fitzgerald, Mann, Cabrera, Sarche & Qin (2010). Remarkable changes in population demographics are occurring in traditionally European or Western countries. For example, considering only birth rates, the United States is already a minority-majority population. Yet, social, educational and health programs reflect historical decisions made by the dominant white majority, rather than decisions based on broad knowledge of diverse cultures or indigenous peoples. Killen, Rutland & Ruch (2011) note that, "interventions to promote equity, tolerance, and justice in childhood are not widespread and are rarely informed by developmental theory and research," (p. 1).

Equally concerning is the slow growth in the number of researchers of diverse cultures so that Western researchers are not over-represented in the population of developmental scientists studying diversity within early development. As Cabrera notes, "intervention science based only on findings of adversity and maladjustment can perpetuate a deficit perspective and promote a harmful stereotype that associates deficits of a select group with an entire group of people who share the same ethnic or cultural origin." (p. 14). On a positive note, a shift away from deficit-oriented research has enabled more researchers to focus on identifying strengths and resilience factors that build positive life course pathways (Cabrera, 2013; Killen, Rutland & Ruck, 2011).

These issues and growing unrest with respect to the increasing callous treatment given to infants and their caregivers

worldwide, prompted a number of infant mental health specialists to propose a symposium for presentation at the 2018 biennial meeting of the World Association for Infant Mental Health (WAIMH). The symposium opened with brief introductory comments on Dye's (1972) definition of social public policy as "anything a government chooses to do or not to do" (Dye, 1972, p.1). Because Dye's definition and approach to policy reflects a linear view of process, others developed approaches based on more systems-based concepts of public policy (Yoshikawa & Hsueh (2001). Anderson's (2003) assertion that policy represented a "purposive course of action or inaction undertaken by an actor or a set of actors in dealing with a problem or matter of concern (p.2)," and John's (1998) observation that, "Public policy making can be characterized as a dynamic, complex, and interactive system through which public problems are identified, legislated and countered by creating new public policy or by reforming existing public policy (p.2)" were noted. McKinney, Fitzgerald, Marie-Winn and Babcock (2017, p. 168) note that public policy stresses, "standards instituted by governmental and /or regulatory agencies that establish expectations for behavior or levels of professional performance in public health, education, and overall public welfare with emphasis on social justice."

The symposium provided four case examples that cover much of the range of both linear and systems concepts of policy. Catarina Furmark (Sweden and Nordic countries) reviewed efforts to strengthen policies and practices across the Nordic countries (Finland, Norway, Denmark, Iceland, and Sweden). Catherine Maguire (Ireland) drew attention to intra-governmental agency early childhood policies and practices in Ireland that lack co-ordination and thus are limited in their collective impact nationally. Jane Barlow (United Kingdom) focused attention to infant mental health programming in the United Kingdom, reviewing how it is attempting to "catch up" after failing to act on early childhood initiatives in the past. David Willis (United States) reviewed the history of policies in the United States affecting early childhood education, and its new policies related to home visiting programs and new efforts designed to implement policies reflecting an infant mental health perspective.

We opened the symposium with simple, but profoundly important statements taken from the WAIMH position paper on infants' rights: "Specifying the unique needs and rights of the child in the first years of life is needed in order to motivate infant oriented actions and policies at both

community and societal levels." Stated somewhat differently: We need to value babies and very young children; keep them fed, safe, nurtured, loved, protected from abusive or neglectful care; and, we need to value and support mothers, fathers and all others who provide babies with care. In discussing science to policy and practice", distinguished, multi-disciplinary, multi-university authors offer three core principles to guide policy makers and program developers to improve outcomes for children and families (Center on the Developing Child at Harvard University, 2017).

1. Support responsive relationships
2. Reduce sources of persistent or toxic stress
3. Strengthen core life skills

At the center, always, are strong, supportive relationships: "Starting at birth and continuing throughout life, our ability to thrive is affected by our ongoing relationships and experiences and the degree to which they are healthy, supportive, and responsive or not." (Center on the Developing Child at Harvard University, 2017, p. 2).

Panel participants suggested elements that are essential to assure healthy growth and development in infancy and early childhood. Each element includes a focus on relationship:

- *Healthy relationships with stable, nurturing caregivers
- *Strong and supported parents who are seen as "mediators of change" as they enter into sensitive, responsive, and nurturing relationships with their infants and young children
- *Coordinated and dedicated funding to support a service continuum—promotion, prevention, intervention, and treatment—prenatal to 3, for all families – with relationship work at the center
- *Reduction of child poverty through focus on two-generational or relational strategies that reduce the social and emotional risks of infancy and stresses of early parenthood and address the wellbeing of infants, very young children, caregiving families, and communities
- *A well-prepared, high quality, multidisciplinary work force that is relationship driven

Over 50 years ago, outstanding leaders in the infant mental health community laid the foundation for contemporary practice and thinking. Three come to mind. All

focus on babies and relationships:

*Donald Winnicott stressed, "There is no such thing as a baby, only the baby and those caring for the baby," urging attention to early developing relationships. (Winnicott, 1964)

*Selma Fraiberg asked, "What about the baby?" urging policy makers and practitioners to think about the baby, bring the baby into focus, understanding the needs and rights of babies to loving relationships, and strategies to reduce the high risk of relationship failures. (Fraiberg, 1980)

*John Bowlby, contributed attachment theory as a cornerstone for understanding the early organization of mother-infant relationships. (Bowlby, 1969)

(Note: Infant mental health researchers and practitioners need to be reminded that a positive early relationship is not an inoculation for positive subsequent life-course outcomes, but a powerful contributing force.)

In his edited collection of Rene Spitz's papers, Robert Emde (1983, p. 201) quotes Spitz as saying, "Every successive organizer in the further course of development introduces a new formula of relations, successively more complex and better adapted." Positive life course outcomes require positive adaptive changes at minimum in both children and their caregivers in order to build upon and sustain "Good Starts."

As panel members stressed, bringing the infant to the attention of policy makers and understanding parents, as "mediators of change" through two-generational support services, has been a slow, challenging process.

In a National Science Foundation report on University-Led Cooperative Engagement Approaches to problem-solving involving environmental and agricultural domains, the emphasis in these initiatives is on trust building and social learning in collaboration with key stakeholder groups such as farmers, coastal landowners, minority groups, and industry members.

What are the equivalent initiatives for studies of early human development? Solution focused programs generated by homogenous populations, do not always work for heterogeneous, richly diverse populations. In short, the "White" model is not necessarily the Right model! We need to have greater respect for indigenous and local knowledge. Are we framing the right questions when people not of poverty or color, study people in poverty or of color? Where are local or indigenous voices in

the formulation of research questions, voices that may lead to substantially different questions or approaches to research, because of the inclusion of tacit knowledge from the world of lived experience, rather than from the world of university, disciplinary-anchored world-views of relationship dynamics or culturally evolved family structures?

As so clearly articulated by our panelists, the significant challenges that interrupt pathways to good mental health in infancy and early childhood are real:

- *Chronic underinvestment in infancy & early childhood
- *Fragmented efforts to implement or sustain services for children 0-3, especially services supporting social and emotional health and infant mental health
- *Persistent child and family poverty, increasing the burdens of vulnerability in infancy and early childhood and stress in early parenthood
- *And, the resurgence of racism and discrimination linked to increased migration of human populations throughout the world.

Astonishing prevalence data on the extent of mental health problems among children 1-5 years of age make us pause as we realize that we are falling short of protecting the needs and rights of children and supporting families to assure a healthy course of development. Such data fail to include the millions of young children living through war and extraordinary injustices. The time to act is now; babies and their families cannot wait.

As our panelists reported, there are some hopeful signs. Each has referenced effective, practice-based structures and evidence based work that exemplifies infant and early childhood mental health informed practice, service, training, and/or research:

- *Ireland's public resources and proactive supports, beginning in pregnancy, extending into early childhood, and focused on systems level support services,
- *The United Kingdom's Early Excellence Centres, Parenting Early Intervention Programs, Sure Start, 1001 Critical Days, and home visiting,
- *The Scandinavian Child health system's relational health screening, monitoring, and promoting infant mental health
- *The United States' endorsement approach to workforce development through the professional recognition of knowledge,

skills and reflective practice experiences

Dr. Weatherston inclined to say, "For crying out loud, we know what infants, very young children, caregiving families, and communities need. We have identified successful strategies and programs that address infancy and early childhood, with a focus on infant mental health, but many, many infants and families are underserved. What is getting in the way of developing strategies and implementing programs in resource rich countries to meet the needs across a service continuum – promotion, prevention, intervention, treatment – to better assure that all babies and families are free from risk?"

Is it in the language we use? Can we together discover how to convey best what we know to be true about early human development, the power of relationships to effect change, the impact of nurturing care on early development, the effect of early intervention on the reduction of risks? Can we learn to communicate clearly and effectively so that policy makers and program developers in multiple domains will hear us and take action on behalf of all infants, families, caregivers, and communities?

In 1980, Selma Fraiberg's commented:

Today, we are in possession of a vast scientific treasure acquired through the study of normal and (deviant) infants, a treasure that should be returned to babies and families as a gift from science. (Fraiberg, 1980, p.3)

We are beginning to do this – to translate our scientific understanding – our knowledge about babies, their needs and rights, and the power of caregiving relationships in which they develop and grow – to those who can effect meaningful change, the policy makers, program developers, and legal community. However, our science needs to be better informed by views that do not implicitly or explicitly support a hierarchy of human values, where Western, Educated, Industrialized, Rich and Democratic (WEIRD) cultures posit that people are "autonomous individuals with wants, needs, and preferences that should be fulfilled." Where are relationships and communities in such WEIRD cultural value orientations?

We challenge everyone – scientists, educators, practitioners, the judges and legal community, policy makers - to talk with each other, to engage in relationships,

to support one another, to share particular challenges and successful solutions, to collaborate with one another across countries to bring real change through infant mental health informed policies and practices for all babies, all families and all communities.

We challenge WAIMH to establish an Infant Mental Health Science to Policy and Practice Task Force. To meet regularly using the technology we have available to span the globe, and to begin the process as we "specify the unique needs and rights of the child in the first years of life in order to motivate infant oriented actions and policies at both community and societal levels." If the World Association for Infant Mental Health does not boldly address trans-cultural policy issues supporting infant mental health, WHO WILL?

Contact the WAIMH Office if you are interested in joining an Infant Mental Health Science to Policy and Practice Task Force: Office@waimh.org

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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 or Associate Editor, Maree Foley, maree.foley@xtra.co.nz

INTRODUCTION TO “COULD OR SHOULD A ROBOT REAR A BABY?”

By

Maree Foley, Co-Editor, Perspectives,
Switzerland

Stellenbosch University, Cape Town South Africa offers an MPhil degree in Infant Mental Health (IMH). This degree is the first MPhil in IMH to be offered on the African Continent. This programme is convened by Emerita Associate Professor Astrid Berg and Dr Anusha Lachman. As part of the programme, Professor Linda Richter (Witwatersrand University, Johannesburg, South Africa, invited the students to apply what they were learning about infant mental health to the rapidly developing field of artificial intelligence. The article below, “Could or should a robot rear a baby” (Carmen Andries, Brenda Cowley, Lucky Nhlanhla, Julia Noble, Tereza Whittaker, Elvin Williams, Bea Wirz, Anusha Lachman, Astrid Berg, Linda Richter) provides a collation of ideas and reflections from the students with their teachers. These reflections relate directly to the intersection of IMH principles and practice with the artificial intelligence technology; specifically, that which is directly related to the antenatal, postnatal and early childhood periods of development. Salient questions for further reflection, individually or in a group, appear at the end of this article.



Could or should a robot rear a baby?

By Carmen Andries, Brenda Cowley, Lucky Nhlanhla, Julia Noble, Tereza Whittaker, Elvin Williams, Bea Wirz, Anusha Lachman, Astrid Berg, Linda Richter

Stellenbosch University, Western Cape,
South Africa

Could or should a robot rear a baby? This question was posed by Linda Richter in an assignment to postgraduate students in the new Master of Philosophy in Infant Mental Health at Stellenbosch University, South Africa. What follows, is a collation of our efforts to address this question. We do this by exploring the potential for robots at different steps in a caregiving role for an infant, such as robots as a womb, as caretakers, and educators. We also explore potential emotional consequences and ethical considerations, as well as exciting possibilities of artificial intelligence (AI)-assisted caregiving models.

Introduction

We live in an era of rapidly developing artificial intelligence (AI) that is revolutionizing the world and our interaction within it and with each other. Some see AI as posing serious threats, illustrated by the open letter submitted in August 2017 by Elon Musk and other CEOs of technology companies to the United Nations, urging a ban on AI in weapons before the technology gets out of hand. On the other hand, no one is untouched by Judith Newman's book *To Siri with Love*, which describes how the automated assistant helped her son communicate, and be polite, and how it became his friend. Judith Newman notes in a review that “Siri's responses are not entirely predictable, but they are predictably kind”. (“To Siri, With Love: A mother, her autistic son, and the kindness of a machine - Judith Newman - Google Books,” n.d.)

Robots like *Hello Kitty*, companies testing robots to monitor children in nurseries in Japan, and the pervasiveness of digital devices in the interface between parents and children, prompt questions about

the technological and economic benefits, and pitfalls of digital reliance and robotic assistance, but more importantly the potential impact on nurturing care as a fundamental need of human beings.

In what follows, we reflect on the concept of nurturing care and then consider what robots could and could not provide for children and families. We then raise some ethical issues that need to be considered as AI applications progress and become commercialized.

Nurturing care

Adult potential to provide, and infant dependence on, nurturing care is a feature of our human evolution and is the basis of human emotional, physical, and cognitive development. Nurturing care comprises the environment and caregiving responses that maintain and promote the health, nutrition, safety and security, responsive caregiving and opportunities to learn that facilitate a child's attempt to connect to and learn about their world (Black et al., 2017) with inadequate and inequitable access, especially for children younger than 3 years. New estimates, based on proxy measures of stunting and poverty, indicate that 250 million children (43%).

Donald Winnicott (1964) stated that "The proper care of an infant can only be done from the heart; perhaps I should say that the head cannot do it alone..." (Winnicott, 1964) (p 105). But what does "proper care", the "heart" and the "head" really mean?

It is now recognized that "proper care" of an infant, needs to be sensitive to the physical, cognitive, and emotional needs of a child. With respect to the head and the heart, the interactions between baby and intimate caregiver are a complex blend of physical sensations - touch, smell, sound, sight, and taste, which Deborah Rosenblatt described as a "reciprocal multisensory exchange" - as well as the caregiver's responsiveness to cues and the baby's high sensitivity to contingency.

Mary Ainsworth and others have described qualities such as parental sensitivity and responsiveness as "the mother's ability to perceive and to interpret accurately the signals and communications implicit in her infant's behaviour, and given this understanding, to respond to them appropriately and promptly" (Ainsworth, Blehar, Waters, & Wall, 1978).

This sensitivity and responsivity is developed and fine-tuned over time by shared experiences and increasing knowledge of each other. For example, a

mother may respond differently to a child crying because she has dropped her toy than to a child who is crying because she has been hurt. A child's over-reaction to a minor event may alert a caring parent to the possibility that something else is amiss with their child. The cause may be only tangentially related to the present circumstances. A caring and engaged adult is able to use emotional resonance, creative and reflective thought to piece together possibilities of the cause of a child's distress and respond empathically.

Daniel Stern (Stern, 1985) speaks about emotional attunement, in which the mother communicates to her baby that she is receptive to his or her feelings. According to Stern (1995), these maternal behaviours emanate from the "maternal constellation", the mother's instinctual focus on and devotion to her infant, which he and others before him, such as Winnicott, consider to be critical to a child's development.

Fonagy's concept of mentalisation, or "mind mindedness" allows predictions of what an infant may be thinking or intending by his or her actions, expressions, and body language. When a mother imitates or reflects their baby's emotional state in their facial expression, it helps the baby to form a representation of their own emotions. Similarly, on encountering the unfamiliar, infants look to their mothers for clues about how to behave, a response termed "social referencing" (Feinman, 1982). A mother provides clues about the dangers, or safety of situations or people, particularly by means of her facial expressions and bodily gestures.

This social biofeedback leads to the development of a second order symbolic representation of the infant's own emotional state (Fonagy, Gergely, & Target, 2007) and facilitates the development of the child's ability to empathise, and understand the emotions and intentions of others.

One of the key functions of a caregiver is to provide appropriate regulation for the infant's emotions, as the "regulation of affect is central to the adaptive function of the brain and the organizing principle of human development" (Schore, 2001, p.9). This coping capacity in human infancy is mediated by the maturation of brain systems and influenced significantly by the infants' early interaction with the caregiver. It is suggested that even subtle variations or changes in maternal behaviours can affect stress reactivity in the developing infant.

The development of speech and language depends on the attuned input that the child receives from the caregiver. Language interactions between very young children and adults are transactional in nature, responding to each other and changing over time. Caring adults continuously assess their child's comprehension abilities through both language and non-verbal cues and change their behaviour to match and encourage development, extending the infant's range where appropriate through scaffolding.

What could robots provide?

A robot may be able to be responsive and consistent, but could a machine be programmed to support the complexities of a constantly evolving reciprocal relationship of care and trust? We explore this by thinking about the potential for robots as steps in a caregiving role for an infant.

A robot womb?

One day it might be technically possible to grow a baby without a human womb. Three stages in the development of a human embryo and foetus have been described in this automated process. The first is in vitro fertilisation (IVF), which is already routinely carried out in a lab. Fully automating the IVF process is plausible, in the near future. Using already fertilised eggs, scientists have shown that embryos can be grown in the lab for two weeks after fertilization.

The second stage is that of early gestation, prior to around 22 to 24 weeks, when a foetus does not have viable lung function. During this time, the embryo would need to be housed in an artificial uterus. Perhaps unsurprisingly, there has been a great deal of research into the development of artificial wombs; a field of science known as ectogenesis. In a 2011 paper, Dr Carlo Bulletti and colleagues re-evaluated the chances of a laboratory uterus that would supply nutrients and oxygen to an incubated foetus and would be capable of disposing of waste materials. They concluded: "[...] the growth and development of fetuses between 14 and 35 weeks of pregnancy... is within reach given our current knowledge and existing technical tools" (Bulletti et al., 2011, p. 127).

The final phase of foetal development can already be managed outside a mother's womb. If a baby is born after 26 weeks in a modern hospital, it has very good chance

of survival with incubation and support.

Given all of this progress in the science of artificially keeping a baby alive, it seems less “science fiction” and a more plausible reality to consider that babies could be grown in and born from machines in future. Once a robot has grown a baby, birthing will likely be easy. It may be as simple as opening a door on a machine and cutting the umbilical cord.

In turn, machine pregnancies could be helpful for mothers who are sick, receiving invasive treatment or who are addicts and want a drug free baby. However, the research on babies in utero and their relationship to the mothers’ voice, heartbeat and that of other close family members like the father and siblings, tells us that babies in utero are already actively engaged in creating the building blocks for relationship building. Similarly, the mother and or the parent dyad are also engaged in a getting to know the baby as a person process. So, while plausible, it may be that a robot assisted pregnancy will always need a human person from which the baby in utero can form an interpersonal relationship? As most parents discover, birthing a baby is only just the beginning! The next 18-plus years of nurturing care develop intelligence, language, personality, and humanity.

Robots as educational and caretaking tools?

Robots can be important educational tools for children and may even stand-in as caregivers. For example, Sharkey and Sharkey (2010) list some of the positive responses of parents when they were interviewed regarding the Hello Kitty Robot. These included:

“Since we have invited Hello Kitty (Kikki –as my son calls her), life has been so much easier for everyone. My daughter is no longer the built-in babysitter for my son. Hello Kitty does all the work. I always set Kikki to parent mode, and she does a great job. My two year old is already learning words in Japanese, German, and French.”

“As a single executive mom, I spend most of my home time on the computer and phone and so don’t have a lot of chance to interact with my 18-month-old.

The Hello Kitty robot does a great job of talking to her and keeping her occupied for hours on end. Last night I came into the playroom around 1am to find her, still dressed, and curled up sound asleep round big plastic Kitty Robo. How cute! (And how nice not to hear those heart-breaking lonely cries while I’m trying to get some work done).”

“Robo Kitty is like another parent at our house. She talks so kindly to my little boy. He’s even starting to speak with her accent! It’s so cute. Robo Kitty puts Max to sleep, watches TV with him watches him in the bath, listens to him read. It’s amazing, like a best friend or as Max says “Kitty Mommy!” (P2-3)

It is evident that, in these cases the Hello Kitty robot, is doing a number of things right, at least in part to relieve tired and stressed parents with little other support and provide attention and companionship to lonely children.

Another example is iPal, a 90-cm high child-sized babysitter nanny robot [with big eyes and a tablet attached] designed to take on adult responsibilities. (“This Robot Takes Care of Your Children,” n.d.) The robotic baby sitter is able to keep 3-to 8-year-old children entertained for “a couple of hours” without adult supervision. It is able to communicate using natural language, and according to its founder Jiping Wang, “is not a cold, unfeeling machine, but a great companion for your child. iPal’s emotion management system senses and responds to happiness, depression and loneliness: iPal is happy when your child is happy, and encourages your child when he is sad”. (ibid)

Can robots be sensitive, responsive and in tune with a baby?

From the robot’s side, can the process of relationship development be programmed? In humans, it is a complex physical and emotional process that depends in part on the release of oxytocin and vasopressin hormones, physical closeness and emotional intimacy. This natural, organic process would have to be re-constructed through ongoing

machine learning algorithms that adapted continuously to the baby’s initiatives and responses. Based on current robotic learning with respect to facial expressions, this might be technically possible, even sooner than we think. But would it work to sculpt the mental and emotional life of a young human being?

The potential of AI to enhance human emotional learning, is highlighted by Judith Newman in the aforementioned book which tells the story of how the electronic personal assistant “Siri” helped foster the communication skills of her autistic adolescent son, Gus. A child with autism who finds it hard to read emotions, recognize emotional reciprocity and struggles with unpredictability, may find it easier to converse with an inanimate and programmed robot-like Siri who gives accurate, predictable and tireless attention and, in the case of Gus, ultimately translated into his ability to have more conversations with other human beings.

In the future, AI is likely to get to a point where a robot may be able to simulate sensitive and responsive caregiving and may in fact do it quite well. For example, Beebe’s second-by-second research on the micro-responses between mother and infant in serve and return interactions (2010) could possibly be learnt by a robot (Jaffe, Beebe, Feldstein, Crown, & Jasnow, 2001). Other skills such as contingent mirroring and non-contingent responsiveness may also be able to be programmed. Robots could also be programmed to not “get it right” 100 percent of the time, to avoid the dangers and deprivations of perfect mothering (Hopkins, 1996). Perhaps 70 percent would be optimal? The robotic caregiver who is not plagued by ghosts in the nursery (Fraiberg, 1987) or overwhelmed by trauma or stressful environmental circumstances, could possibly provide the consistency and containment so necessary in the life of the infant.

The pace of developments is amazing. For example, scientists in Russia claim that they are on the verge of creating an emotional computer which could think like a person, and build up trust, and bond with humans. It will be used to play the role of a person, will understand the context of conversations, keep up with events and set its own goals. The system’s name, ‘Virtual Actor’ was chosen because one of the main functions it will serve will be as an actor, playing the role of a specific person [Prof Samsonovitch, National Research Nuclear University in Moscow]. (“Russian Researchers Launch ‘Virtual Actor’ in 18 Months,” n.d.)

Therefore, it is not too far-fetched to argue that one day, being reared by a robot is not only a possible, but for some children may not be such a bad thing. Perhaps interacting with a robot with a highly sophisticated artificial intelligence may be better than being raised by parents who are neglectful and abusive. Perhaps in situations such as large group orphanages, human infants might do better with the companionship of a robot carer than with little human caregiving at all. Robots would at best be insensitive carers unable to respond with sufficient attention to the finer needs of individual children, but able to be consistent providers of day-to-day care.

This rapidly expanding technology, boosted by the motivating forces of efficiency, multitasking and profit, provide immense challenges for our infant mental health field. It is to some of these challenges we now turn our attention to.

What can a robot not be?

A robot's ability to read emotions, interpret them, and respond appropriately - its reflective function - would need to be extremely sophisticated to be able to provide the "real-time" emotional responses necessary for successful emotional communication and affect regulation, both necessary for a young child's healthy development. To enable "flexible, goal-directed caregiving" a robot would need to master empathy and mentalising functions, as well as affect regulation (Feldman, 2015).

If a robot could learn to differentiate the infinite variations of a smile, for example, would it also be able to display them in a way that could be read by a living human being? As the robots become more and more humanoid, there may occur a switch from our usually positive and empathic response of the adult perceiver to robots to a revulsion, a process which Mori described as the "uncanny valley". The more like a human an entity is, the less there is an affinity for it, because of an increase in a sense of "eeriness" (Valley, Mori, & Minato, 1970). We could hypothesize that somewhere in their unconscious minds, babies will be aware that there is no genuine human heart beating under that well-constructed robotic exterior. When robots do not provide a coherent sensory 'Gestalt', the consequence could be an insecure attachment.

Ethical considerations

In their article "The crying shame of robot nannies", Sharkey and Sharkey (2010) explicitly articulate ethical issues, psychological challenges and potential outcomes for society and especially for children.

While looking at their potential benefits we need to be conscious of the fact that no matter how good a machine is, it will never be fully able to override the intrinsic features of human relationships. Robots might be able to classify emotions and respond with matching expressions but rearing a child requires cultural embeddedness, the personality of the child, and other factors. Melson, (2010), investigated negative consequences of technology replacing human interaction and reported that if children begin to personify robots as living creatures, they are susceptible to develop robotic understandings of humans, bereft of moral standing.

Advancement in technology is bringing AI into our personal lives and creating an illusion that robots are able to understand human behaviour and respond emotionally to us. The risk, especially for children, is that this could lead to misplaced trust in robots. Research has shown that children tend to see robots as alive, and feel an emotional as well as intellectual connection with them. (Turkle, Breazeal, Dasté, & Scassellati, 2006) The question arises: are the children being deceived?

Alan Winfield, an expert in robot ethics, argues "that robots should never be designed to deceive.... their machine nature should be transparent. We're concerned about vulnerable people - they might be children, disabled people, elderly people - coming to believe that the robot cares for them." ("Would you want a robot to be your child's best friend? | Technology | The Guardian," n.d.) Indeed, that may be the crux of the matter, as infants and young children will not be able to grasp that the robot nanny is not 'real' and they will be the ones most in need of protection against deception.

There are also questions of who bears responsibility for what the robot does, for any harm it may inflict? Who will have access to its hard drive where information is stored? Will the child in later life have the right to destroy recordings? It would be timely for this to be thought about sooner rather than when it may be too late. And what about the robot - do we have an ethical obligation to what we have created? "...as robots begin to gain a semblance of emotions, as they begin

to behave like human beings, and learn and adopt our cultural and social values, perhaps the old stories need revisiting. At the very least we have a moral obligation to figure out what to teach our machines about the best way in which to live in the world. Once we've done that, we may well feel compelled to reconsider how we treat them." (Simon Parkin, writer & journalist; author of "Death by Video Games"). ("Teaching robots right from wrong | 1843," n.d.)

Conclusion

Whilst much of the science of the "heart" and the "head" in parenting, is as yet undiscovered, some of the biological and psychological bases of love seen in the behaviour of humans raising baby humans, has been described. We know that parenting has evolved through the long adaptation of mammals and primates to enable infant development to be uniquely fit for human culture through the unique human bond that forms between a baby and their adult caregivers. As well as being central to the healthy development of the individual child, these same emotional bonds are the root from which the complex social systems necessary for human survival stem.

Although it does seem possible that robots could one day create new humans and raise them into adulthood, would such humans see their robot parents as a mother and father in the traditional sense we know today? Rather than perfecting robots, should we not rather put our resources into supporting parents in their important roles, including with the help of AI innovation?

This salient and thought-inciting article lends itself to the possibility of being utilised as a springboard for small group discussions, for example, in a classroom, or among WAIMH affiliate groups. As such, the following reflective questions are offered that could be used to help structure the beginnings of a group-based discussion.

1. What IMH principles do you think are necessary to highlight as artificial intelligence technology expands into the antenatal, post-natal and early childhood areas of development?
2. James McHale defines coparenting as «an enterprise undertaken by two or more adults who together take on the care and upbringing of children for whom they share responsibility.» Coparents may include members of the child's extended family, foster parents

and or other specialized caregivers. What can we learn from the theory and practice of coparenting that might be applied to the way this new technology is used with the infant in their coparenting context?

3. IMH is an intergenerational field. What might it mean for infants raised increasingly by artificial intelligence technology when they become parents and/or part of a coparenting team?

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Book review

The Emotional Life of the Toddler, Alicia F. Lieberman, New York: Simon & Schuster, 2018

(Revised and Updated Edition), 321 pp., \$16.00

Alicia F. Lieberman, Ph.D. received the Rene Spitz Lifetime Achievement Award from WAIMH in 2016. The author of many books and publications, she is revered around the world for her work related to early developing attachment relationships. Originally from Paraguay, Dr. Lieberman resides in California where she is the Irving B. Harris Endowed Chair in Infant Mental Health and professor in the department of psychiatry at the University of California, San Francisco.

Reviewed by Deborah Weatherston, USA

While reading Alicia Lieberman's updated edition of "The Emotional Life of the Toddler," I fell in love with toddlers all over again! Dr. Lieberman captures the wonder and complexity of emotional development in the early years, firmly addressing the safety and security of early development within the parent-child relationship. She gives voice to the rich and deeply felt emotional world of very young children, helping parents appreciate the dynamics of growth and offering practical examples to guide parents through this crucial stage of development.

Not surprisingly, Dr. Lieberman places her observations about very young children and their caregiving parents squarely in the framework of attachment, in which parent and child negotiate a balance:

..... between the safety of closeness and the excitement of exploration and discovery.

In this sense, childhood is an early laboratory for the challenges and dilemmas of adult life. Perhaps more dramatically than any other age, this period brings us face to face with two powerful yet contradictory impulses: the longing to feel safe in the protective sphere of intimate



relationships and the exhilarating thrust of carefree, unrestricted, uninhibited exploration, where one can soar free without looking back at those who are left behind P. 13

However, as Dr. Lieberman describes in detail, the negotiation in toddlerhood is not without challenge. Throughout, Dr. Lieberman is sensitive to the toddler's needs, as well as to the parent's experience, in achieving that balance. She illustrates her thoughts about obstacles to partnership with many vignettes, bringing to life reflections about temperament and the question of "the fit" (whether the toddler is described as a high-activity or slow-to-warm up child) and its meaning or impact on the developing relationship.

Dr. Lieberman tackles with great sensitivity issues to understand: separation anxiety, nighttime difficulties, eating difficulties, sibling rivalry. She is careful to offer practical suggestions to encourage parental awareness and response that is likely to reduce the difficulty and lead to greater emotional security. She attends to marital discord and the disruption of divorce, careful to give voice to the toddler's experience while supporting a parent's capacity to provide a stable base in the midst of difficulties. Her chapter about toddlers in childcare offers support to the whole family in making the transition to care, "saying good-bye",

"saying hello," and identifying the social realities of care for everyone.

I ended the book with a much greater respect for the power of the early attachment relationship and the toddler's astonishing capacity to master staying close, while letting go.

Dr. Lieberman concludes with wise words:

Toddlers, like adolescents, need to forge an identity that integrates a solid sense of personal initiative with a reliable feeling of communal belonging. Parents are faced in both periods with the task of deciding when to respect aloneness, when to offer companionship, and when to exercise firm authority. When parents' choice is responsive to the child's needs, the negativism of toddlers becomes the self-assured assertiveness of the preschool years, just as the emotional storms of adolescence resolve themselves in the self-worth of young adulthood. P. 306

This should be required reading for each one of us who has a toddler to marvel about in our own families or in those with whom we work.