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Perspectives in Infant Mental Health

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Contents

President´s Reflections

By Miri Keren, M.D., WAIMH President, Israel, ofkeren@zahav.net.il

Dear WAIMH members and friends,

It is time now to update you on the major activities our WAIMH Board members have been working on since our last WAIMH Conference in Edinburgh. Indeed, considering the distances we live from one another around the world, we have achieved quite a lot in-between our face-to-face meetings at our biennial conferences. Advanced communication techniques, combined with a very highly motivated Board, have made it possible to work on many things.

We are currently working in parallel on three main projects: the Infant's Rights Declaration, the revision of the DC0-3R classification system, and the preparation of the 2016 Conference. Let me update you, one by one.

The Infant's Rights Declaration

Those who attended the Presidential Symposium at the 2014 Edinburgh Conference heard about the rationale and the process that led to the decision to compose an Infant's Rights Declaration. The draft document has also been circulated for comment among the membership. There has been a very lively, on-going discussion about the need for a declaration of our own, an Infant's Rights Declaration, in addition to the declaration that has already been prepared for the Children's Rights Convention.

When creating WAIMH, we could have asked the same kind of question: Why did we need to create an association of our own for infants when there were already professional associations who dealt with child and adolescent mental health (IACAPAP, ESCAP) or educational or pediatric associations?!

We need WAIMH to give voice to the uniqueness of the infancy period. Hence, we see ourselves obliged to provide a document that reflects and articulates WAIMH's values, its sense of the policies and practices that will produce the outcomes defined in the principles. The main aim of the Infant's Rights document is to provide a clear voice and direction to everyone who belongs to WAIMH and its Affiliates. Of course, we support the Children's Rights Convention. The final version of the Infant's Rights document, which we are working on these very days, will make clear what is special about infants, their needs and rights. The last step will be to try to establish this statement as an addendum to the Children's Rights Convention.

Revision of the DC 0-3R

The revision of DC -0-3R, the *Diagnostic Classification for Emotional and Developmental Disorders in Infancy and Early Childhood*, has been initiated by ZERO TO THREE (ZTT), under the leadership of Charley Zeanah Jr., and has become a joint ZTT / WAIMH venture. The DC-0-3R Task Force, made of clinicians and researchers in the field of infant and preschool mental health (Charley Zeanah, Alicia Lieberman, Alice Carter, Helen Egger, Mary Margaret Gleason, Miri Keren) is working very intensively, through international videoconferences and in-person meetings, on each of the diagnostic categories, reviewing the relevant studies that have been published in the last 10 years, as well as bringing in their own clinical experience. Although it requires a very big number of work hours, this is an extremely dynamic and

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

WAIMH Central Office
University of Tampere, Medical School, Laakarinkatu 1, Arvo-building Room C221, 33014 University of Tampere, Finland
Tel: + 358 50 4627379, E-mail: office@waimh.org, Web: www.waimh.org

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interesting process. We will be happy to share it with you during the conference in Prague, just a few months before sending it to ZERO TO THREE for publication. Stay tuned!

WAIMH 2016 Conference: Infant Mental Health in a Rapidly Changing World: Conflict, Adversity and Resilience.

As most of you already know, the 2016 WAIMH Conference has been transferred from Tel Aviv to Prague, for reasons we have explained in detail in a previous issue of Perspectives. The Scientific Committee and the Local Committee are already working at full speed and the first Call for Papers will be launched by the end of this month. Creativity and flexibility are needed to organize this conference in unusual circumstances, and this, in itself, has become an adventure. We hope to get as many abstracts as we got for the enormously successful Conference in Edinburgh!

Thank you for the work you are each doing in your own corner of the world.

Very warm regards to all of you, Miri Keren, WAIMH President

From the Editors

By Deborah J. Weatherston, Editor, Michigan, USA,

dweatherston@mi-aimh.org,

Hiram E. Fitzgerald, Associate Editor, Michigan, USA, fitzger9@msu.edu,

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

Joshua Sparrow, Anna Huber and Angela McLaughlin, Contributing Editors

This Issue has been put together with great enthusiasm and an abundance of care. The editorial staff provided lots of suggestions and feedback; the authors submitted papers that represent a great deal of hard work, provoking us to think more deeply about research, community, policy and practice focusing on the developmental and relationship needs of infants and very young children. We thank them for their contributions.

Miri Keren, discusses the policy work that WAIMH has been engaged in for the past 3 months in her President's Column. The World in WAIMH introduces Niels Rygaard, a Danish consulting psychologist who raises important questions about infancy research in his article, " Infant Mental Health in the Global Village." Connie Lillas, a family therapist and analyst from Southern California and Mary Ann Marchel, research faculty from the University of Minnesota Duluth, challenge traditional research assumptions and practices in their paper in which they look at dynamic systems theory and its influence on research, cultural disparities, and shifts that support the IMH field. Kaija Puura, Associate Director, provides a window into her recent journey to Fukushima where she discovered again the power of community to support the healing process. Maree Foley and Ana Huber, Affiliates Council Chair and Representative, respectively, bring news about affiliates around the world. Angela McLaughlin features the work of masters and doctoral students in infant mental health research. Finally, in recognition of the Infant Mental Health Journal and its contributions to our work, and with permission, we invite readers to read one article from the first issue of the IMHJ, Through the Eyes of a New Dad: Experiences of First-Time Fathers of Late-Preterm Infants; Karen M Benzies, University of Calgary, Canada and Joyce Magill-Evans, University of Alberta, Canada *Infant Mental Health Journal*, Vol. 36(1), 78-87 (2015).

Clearly, WAIMH's perspective is worldwide. An inclusive organization working on behalf of the wellbeing of all babies, their families and communities, we invite comments and contributions from all over the world. Be sure to share *WAIMH Perspectives*, an open source document, with others in your social media networks.

The World in WAIMH

By Joshua Sparrow, Brazelton Touchpoints Center, Boston, United States, E-mail joshua.sparrow@childrens.harvard.edu

The World in WAIMH is a column intended to generate reflection and dialogue about infancy and infant mental health within our global community. Joshua Sparrow, Director of Planning, Strategy and Program Development at the Brazelton Touchpoints Center (Boston Children's Hospital/Harvard Medical School) conceived of this column in 2013. What follows is a list of articles that have been published in this column to date. They represent diverse perspectives and challenge all of us to think in a variety of ways about infants, families and communities:

Perspectives in Infant Mental Health Vol. 21 No. 3 (Summer 2013)
Child Justice, Caregiver Empowerment, and Community Self-Determination (Excerpts), J. Sparrow

Perspectives in Infant Mental Health Vol. 21 No. 4 (Fall 2013)
Finding a Place for Early Child Development in the Hierarchy of Needs (Excerpts), N. Kendall-Taylor & M. Baran

Perspectives in Infant Mental Health Vol. 22 No. 1 (Spring 2014)
A Community Service Clinical Psychologist Reflects on a Parenting Skills Workshop in Nolungile Clinic in Khayelitsha, Cape Town, T. Dube

Perspectives in Infant Mental Health Vol. 22 No. 2-3 (Summer 2014)
Los Momentos Magicos: A practical Model for Child Mental Health Professionals to Volunteer by Supporting Caregivers in Institutions in Developing Countries, A. Harrison

Perspectives in Infant Mental Health Vol. 22 No. 4 (Fall 2014)
Connecting with South Africa, (Excerpts), A. Berg

Our shared hope is that this will offer space for challenge and interdisciplinary discussion. We are asking the WAIMH community for commentary, field reports, case studies, research articles, book reviews, new submissions and (when proper permission can be obtained) adaptations of previously published articles that may be of interest.

This issue's World in WAIMH column features a fascinating reflection by psychologist, Niels Rygaard, founder of fairstartglobal.com on global and urban trends affecting infants, parents, and the caregiving environments in which they grow and develop. His piece is a challenging and thought-provoking one, and offered with the generous spirit of sparking dialogue among WAIMH members and beyond. We welcome your comments and reactions to Infant Mental Health in the Global Village and look forward to publishing them in future issues of Perspectives.

INFANT MENTAL HEALTH IN THE GLOBAL VILLAGE.

An invitation to reader's debate: Emerging infant environments, and future research

By Niels P. Rygaard

Niels P. Rygaard, Private Consultant Psychologist, Denmark

Email: npr@erhvervspsykologerne.dk

Niels P. Rygaard is a private consultant psychologist in the areas of attachment, deprivation and adoption. By means of advanced technology - such as the Harvard/MIT EdX platform - he created a network to transform child research into the design of open source online training programs for foster care and orphanage systems worldwide.

Introduction

This essay aims to identify some hotspots of future infant research. It was inspired by the 2014 WAIMH Edinburgh conference, and the author's observations from developing international online educations for orphanage and foster care systems. Focusing on risk factors, the text projects current global and urban trends, pointing to possible future environments for infants, in a world where the organization of daily care is undergoing rapid change. The urban infant environment is reflected upon from several perspectives: how may the altering patterns of reproduction, migration and social mobility affect the organization of the family, daily infant care, government child policies, and the abandonment of children? To highlight the impacts of urbanization on family life, Danish examples representative of global statistics are used. The discussion pertains to the areas of theoretical concepts, possible new designs of studies, and the use of technology to disseminate results and professional dialogue with global audiences. (Topics for debate are in italics).

Urbanization, Migration, and Infant Environments

The development of infants reflects their utter dependency of the immediate environment. Thus, to some extent, a short overview of demographic changes in infant environments may encircle future

challenges to research. The UNICEF 2012 theme was: "Children in an urban world". While war, famine, epidemic diseases, and dwindling water supplies represent well known physical threats to families and infants, global urbanization creates a new habitat of human life shaping the social, mental, and emotional organization of early care.

A few figures may illustrate the scale of change: In 1800, only 2 percent of the world population lived in cities. A modest 2014 UN report estimate suggests that "Today, 54 percent of the world's population lives in urban areas, a proportion that is expected to increase to 66 percent by 2050" (DESA 2014). Of the one billion poor, three out of four live in urban areas without shelter and basic services. Twenty-nine percent to forty-eight percent of cities in the developing world have areas considered inaccessible by the police, making infant social services a risky affair. As for infant health, 5.8 percent of children in cities of the developing world die before reaching the age of five (UNCHS 2001).

The overall topic for discussion is simple: How can research identify key areas of improving urban infant environments?

Reproduction: The Reversal of the Age Pyramid and Policies of Infant Care

In urban settings, there are fewer births and more elders: by 2050, the number of persons older than sixty in the world will more than triple, while birth rates decrease (UNCHS 2001). A possible cause of this may be that urban life demands workforce mobility and extensive education. In contrast to rural methods of production, urban life demands exclude children and the elderly by turning them into an economic burden for both parents and society; childhood is extended, and so is old age. In any circumstance, one consequence for developed countries is that parental identity will more often hinge on a single child and so to speak may "overload" the relation with expectations, worries and wishes; that more parents remain less experienced first time parents, and that the child no longer has a number of siblings for peer experiences and relief from parental ambition and worry. The peer group in the daytime outside home tends to replace the rural society sibling and local child group.

In the circumstance of a reversed age pyramid where the influence and needs of the elderly are a dominant political concern, governments may lack the interest, logistics, and means for investment in infant welfare policies: In Denmark for example, the 13.5 percent decrease in birth ratios since 1994 and "the elderly burden" now stress childcare state budgets, eliciting massive budget cuts in kindergartens, schools, institution and foster care placement, and special needs care. In this political game of priorities, the familiar statement of early intervention being the best investment (such as the Heckman Equation (Campbell et al. 2014)) has limited bearing, and government policies are frequently paralyzed by antagonistic parties either preserving traditional values or propagating adjustments to urban life, spurring conflicts over prevention, abortion, and divorce.

How can research influence government infant policies and societal priorities in the case of infants representing a reduced part of developed country populations?

Uneven Tempo of Change - Migration and the Cultural Chessboard City

World countries may be described as being on different stages in a general process of urbanization causing a steep decrease in childbirths when completed, while Africa, Indonesia, Pakistan and the Philippines will struggle with many births. For example, growing from 38 million in 1950 Nigeria is expected to outnumber the U.S. population by 2050 (United Nations, 2014). This circumstance creates the trend that developed countries hold a shrinking proportion of the world population. Europe has long been unable to reproduce populations (Mathiesen, 1983); China is abandoning the one child policy to avoid a future lack of work force (Settles & Sheng, 2008), and a 2008 study of 39,600 Chinese women shows that 35 percent preferred only one child, 57 percent plan for two, and only 6percent percent planned for more (Hesketh, 2008). The decrease seems to be somewhat synchronized with urbanization.

This population void, combined with civil unrest and poverty, creates waves of migration from less to more developed countries--from Africa to Europe, from Latin to North America, from Asia Minor to Turkey--on a scale far exceeding the migration waves that brought down the Roman Empire, leaving many children in their wake. At the moment, such a wave of 3000 Syrian fugitives to Denmark divides the waters between isolationist and globalist political parties, the former parties opposing fugitive family reunion and integration.

One outcome is that any city becomes a multicultural and multiethnic chessboard entity, producing and immediately importing conflicts from other parts of the world (as in the recent Hebdo attack in Paris), border problems, and also spurs innovative intercultural mergers. Religious and cultural concepts of family structure from different cultures co-exist, merge, and clash. In an urban bus, a veiled wife with five children may sit next to a conservative Christian and a hardcore women's lib single mother. Many families have multicultural origins (Fitzgerald, Mann, Cabrera, Sarche, & Qin, 2010). However, in time all urban parents become subjected to the urban environment, and face identical challenges to organize work and childcare.

Is it possible that as like languages and dialects disappear, so will local child rearing traditions be replaced by common sets of urban norms? Much research in cultural diversity stresses cultural differences. Can research explore a basic set of principles to define urban quality infant care?

From Preserving Traditional to Constructing Innovative Urban Parenthood

For urban parents, constructing childcare norms and practices becomes an individually composed task, mixing elements from the original cultural values with their own designs. Caregiving competences and practices are no longer only handed down vertically from grandparents: parents identify horizontally (even internationally) with other parents. Parental identity, authority, and emotional state-of-mind concepts such as family, couple, parent, gender, relative, individual versus group needs, etc. are constantly constructed and re-constructed. From a fixed lifelong structure, the family is liquefied into a process of negotiations between individuals.

Family therapy, parent counseling and mediation are professional responses to this development. How can such methods identify elements to reduce the pain of change and increase the ability to create secure and flexible family relations?

The Organization of Urban Infant Care: The Requisite Membership Family

The rural extended-family-clan base, where

children are not separated before school age and participate in daily production and reproduction seems to dismantle under the urban stress of both parents working, the geographic daily separation of family members, and the transformation of cultural norms in city life.

Denmark, having reliable and detailed data on all citizens, may illustrate developed country trends. In the past 20 years, the number of children 0-2 in daytime care increased from 43 percent to 79 percent. Divorce rates (Danish parents have the longest total work hours in Europe) have now reached 43 percent (1955: 4 percent), peaking at two years after birth of the second child. The frequency of divorce has moved from peaking at nine years after marriage for couples married in 1960, to five years for couples married in 1970, with a higher frequency in urban areas. Since 2000, the number of single maternal and paternal providers increased by 25percent and 50 percent respectively (Olsen, Larsen, & Lange, 2005). Parents tend to be late debutants: most first births are given by mothers 30-34 years, and still less by mothers 15-29 years (figures from the Danish Institute of Statistics).

The fact that we live longer creates serial family memberships. In what may be coined "the requisite family", any membership tends towards temporary, exchangeable actors in the ongoing process of family constructions. Members may or may not be genetic relatives. In the daytime each individual is a member of external groups of identical peers or colleagues within a uniform age span: Child institutions practice strict age limits, and children thus lose the diversity and social interaction of age diverse peer groups. Family constructions frequently break down, and members become actors in other constructions, sometimes with double or triple memberships, or children living with a single parent. Twenty percent of divorce children peddle between parents. Since 2000, the number of single Danish mothers or fathers increased by 25 percent and 50 percent respectively (DIS, 2012).

For infants and toddlers, this organization of care poses an increased risk of separation trauma, loyalty conflicts; and frequent shifts in relations with important attachment figures, as well as with siblings, daycare and kindergarten peers. How do frequent daily caregiver, peer and group shifts affect the attachment process, and child behavior? And how does "age ghetto" care affect the social development of the child?

Society's Response to Insecure Environments: The Child Labeling Diagnostic Culture.

Common child and youth problems in this environment are: low self-esteem, identity problems, suicide and suicide attempts, self-mutilation, eating disorders, learning problems, restlessness, hyperactivity, social phobias, withdrawal, and depression. Treatment designs in therapy, psychiatry and medicine tend to focus on individuals, on parent-child attachment, or at best on families. However, the distribution of child diagnosis seems to be also an urban and cultural phenomenon. For example, the frequency of the ADHD diagnosis is extremely low in Southwestern U.S., and increases gradually towards the Northeast (CDC, 2011). Other causalities of hyperactivity notwithstanding, the stresses of the urban family and restricted physical spaces for child activity may be important contributors to abnormal behaviors. Symptoms of failure to thrive mentally could be interpreted similar to the physical symptoms of urban child obesity (Brody, 2002) and urban cardiovascular diseases (Smith, Ralston & Taubert, 2012).

Do we, so to speak, ignore structural organizational care problems by ascribing them to individual children (and anxious and guilt-ridden parents), instead of interpreting these reactions as healthy and normal responses to intolerable numbers of separations, and increased levels of anxiety, insecurity and stress? Should research further extend the individual and relational focuses to group, intergroup and culture, such as community based interventions? Should we further consider the weaknesses of the DSM system (as does the US National Institute of Mental Health) and search for another paradigm, based on understanding child behavior as a reflection of stressful environments?

Perhaps the basic question is: *to what extent are urban environments suitable habitats for infants, toddlers and their parents, and, do they generate a host of negative long term effects on mental development? If so, can research suggest models for "the resilient infant environment"?*

One example in this direction: a major recent survey of international research since the 1930s concludes that in nurseries and kindergartens, three factors influence long term child development, including higher levels of education as adults: fewer children per caregiver, smaller groups of children, and ongoing education of staff. Positive effects are most prominent in children from disadvantaged risk families. The most important factor is the quality of the interaction between children and adults (Christoffersen, Hoejen-Soerensen, & Laugesen, 2014), concordant with orphanage intervention research.

Multiple Parenting Stakeholders: The Struggle for Continuity in the Puzzle of Daily Care

As stated by Bowlby, infants need a secure base in order to play, learn and explore; i.e. long term social and emotional relations with one or a few caregivers, especially during the first years of life. This basic premise for healthy infant development has been confirmed by epigenetics, neurology, attachment studies, and other disciplines. In less industrialized settings the early care unit is created by the village: the parents, the relatives and neighbors. Inclusion into a long-term secure group of peers gains importance when the infant becomes a toddler. However, the social relations of all urban individuals tend to increase in numbers and daily caregiver shifts, while reducing in stability and longevity, contradictory to attachment definitions of quality care.

In urban settings, the young parent family is only one piece in the puzzle of shifting daytime groups for infant care, and the age limit for the first daytime separations from parents is dropping. Urban parenting skills may be defined as not only the parental provision of secure style care, but also the skills to construct and manage a network of groups where many separate actors are responsible for the child during the day and the week. These actors have a professional - more than a parental attachment-like approach - to their job, they are responsible for groups rather than for individuals, and they have very limited possibilities for intimate individual relations. Professionals too are requisite caregivers: the average general length of job service in Denmark is now down to three years - for social workers managing fragile families, down to nine months in the Copenhagen area. One study indicates that children in foster care develop less well the more often the foster family's social case manager is exchanged (Egelund 2009).

Ways to enhance coherent networks and cooperation between daily caregiving groups, to provide security and continuity in infant relations may be important areas of study, including countermeasures to the effects of caregiver staff mobility.

Developing World Challenges: Children Growing up without Parental Care and Protection

Mostly in developing countries, the centrifugal power of multiple family stressors tends to sling children from parents into orbit. In the global perspective a considerable number of parents are simply forced to give up (nine out of ten "orphans" have live parents, the correct term would therefore be "children without parental care"). This population is estimated to be well over 100 million, out of which some seven million children grow up in orphanages. Sixty-four percent are girls. Five percent of this population is younger than five. The U.S. has more than half a million children in foster or institutional care. As for Europe, 1.5 million are without parental care; out of these some 90,000 are younger than three, and figures increase in spite of lower birth rates. Only some 50 percent ever complete school or get a job, and many end up in prostitution, abuse, gangs, and suffer from personality disorders and reduced social competences (UNCF, 2004). Sadly, this poor outcome may apply even to developed countries (Vinnerljung, 2014). Many expelled children grow up as easy prey for extremist, warmonger, or criminal organizations, and as such pose a future threat to democracy in adulthood in both developing and developed countries (the terrorist brothers attacking Hebdo in Paris grew up in an orphanage).

Why are the outcomes of public and NGO non-family systems so poor, even in countries investing large amounts in care for abandoned children?

Major Challenges in Improving the Lives of Children without Parents

As pointed out in a recent IMHJ editorial (McCall, Groark, & Rygaard, 2014) the lack of government social services systems in developing countries is the major obstacle for care improvement. For example, one relatively developed country, Indonesia, has 250 social workers in a population of 235 million; these workers are also responsible for overseeing the 8,000 orphanages (BPSW, 2010).

In the global perspective, the trend of preferring foster care in favor of institutions may be questioned (McCall, 2014): quality foster care requires strong government monitoring systems, usually non-existent in developing countries. In countries where the extended family is still prevalent (Muslim and Asian cultures), family kinship is the condition for inclusion, preventing the use of foster care. A study of the effect of madrasahs (Muslim orphanages) found positive effects in life development, ascribed to lifelong group membership (Khalil, 2014). In Japan children in foster care are stripped of their family name when placed, are not allowed to see parents while in care, and at age 18 get back their name and are left without aftercare. The result is a high suicide rate among former foster care youth (HRW, 2014) (this author currently cooperates with child psychiatry professor Kamikado Kazuhiro at Nagano University to develop online training programs for Japanese foster care (www.fairstartglobaljapan.org)).

In general, the social-emotional relations quality of care systems seems to be more important than the type of placement, the physical environment, and other variables measured (Crockenburg, Rutter, Bakermans-Kranenburg, vanIjzendoorn, & Juffer, 2008).

One possible pathway for research may be to offer governments large-scale program designs: supporting young parents to keep their babies or re-unite, and intervention programs for urban community responsibility for the same. Training programs for foster carers, day carers and nurseries, supporting and educating parents. Programs teaching professional caregivers attachment and relational based practices, to understand that their professional role is also "in loco parentis.Infants should be offered stable attachment figures in professional environments.

Discussion

In the essay, various aspects of infant urban environments have been touched upon to hypothesize possible pointers to future research, and reflections on how rapid demographic change may call for a revision of how we conceptualize infant research. What seems to be clear is that research and intervention designs must be adjusted to the two realities of developing country settings versus developed country settings.

Revisions of theory and research to comply with urban reality

As an example of a concept revision: attachment theory focuses on the mother-and-child relation. Obviously, the role of fathers is an upcoming area of study, but to set the question at tip: how does this theory apply to the busy urban mother building a network of caregivers, or the Chinese worker who relies on grandparents for care, and sees her child once a year? Constructing a secure urban base calls for combining attachment, group dynamic, and social systems theory in order to reflect reality. For example, can we apply attachment theory to "the secure group", or to "the secure infant care network"? If it takes a village to raise a child, how can we recreate the village in urban care units?

Technology spurring innovative research designs, focusing on vertical validity

As brilliantly demonstrated by Swain (2014) at the Edinburgh conference plenum, we are now able to map what goes on in areas of sensitivity in a mother' brain as she interacts with her two-week old baby. This is only one study simultaneously measuring observed micro-processes and, in this case, neurological and dyadic behavioral interactions.

Such designs indicate that validity is no longer only established by a single discipline by comparing results with other identical method studies (horizontal validity). Also, validity is established as vertical, linking micro-processes to still broader scopes of social interaction patterns (Rygaard, 2007). Studies of infant mental health tend to be produced by interdisciplinary groups of experts, comparing processes measured from different distances to the object (epigenetic, synaptic, cortical, behavioral, interactional, group dynamic, etc.). This development of course makes it difficult to define the borders and areas of validity for any discipline involved, including former borders between somatic and mental research. In psychiatry, Millon's multidimensional diagnostic approach (Widiger, 2007) is one example of this way of thinking.

What innovative theories and interdisciplinary methods may redefine infant research? Can we conceptualize cross-disciplinary models to link organizational intervention studies and inter-group, group, relational, behavioral

and internal physical processes in infants?

Today, WAIMH can be compared to a sizzling stock exchange of diverse infant knowledge. Can the WAIMH forum and other research societies join to design a global interdisciplinary research bank, setting global standards for urban infant quality care, to support systems for infants in the future?

With gratitude towards WAIMH for the inspiring Edinburgh Conference, and the members who generously share their knowledge to qualify the FairstartGlobal project, the author hopes that these reflections may inspire further debate.

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Affiliates Corner

Affiliates Council News

By Maree Foley (Chair of the Affiliates Council), Switzerland

maree.foley@xtra.co.nz

and Anna Huber (Affiliate Council Representative), Canberra, Australia
annahuber.marymead@gmail.com

Greetings to all WAIMH Affiliates. Over the past few months WAIMH has been engaged with a number of key projects such as: preparations for the WAIMH Congress in 2016; the social media initiative; and the ongoing development of the statement concerning infant rights. In addition, the Infant Mental Health Journal (IMHJ) saw a change in Editor-in Chief. We welcome Paul Spicer as the new Editor-in-Chief and say a huge thank you to Hiram Fitzgerald for his work, over many years as Editor-in-Chief.

This brief update alerts you to a few forthcoming Affiliate issues: updating affiliate profiles; a brief survey to update the voting process; and an invitation for you to contact us with any ideas you might have to further develop the Affiliates' Council.

Annual Update of Affiliate profiles

Over the next month each affiliate president will receive an email with a request to update your affiliate profiles. We understand this is another demand on your time however, keeping our profiles up to date with current contact details helps us to communicate efficiently with each other. It's also an opportunity to check how each affiliate is going with regard to maintaining 10 financial members. As discussed earlier, we are here to support affiliates that are struggling with this aspect of their affiliate status. In addition, we acknowledge that affiliates are dynamic social systems, therefore, sustaining close communication between affiliates and the AC is important so we can work together to celebrate each affiliate's work and provide support during more difficult times.

Voting system within the AC

After continuing discussions since 2010 and online surveys inviting your views, we are now ready to invite you to vote. As such in March of this year you will receive an online invitation to vote. To recap, you will be asked to agree or disagree with the following recommendation:

When voting for the election of AC officers: each affiliate will receive one vote except in cases where:

An affiliate is made up of more than 1 country.

In this instance, each country within that affiliate (up to 5 countries) will hold one vote each; and

In countries where there are more than 1 affiliate.

In this instance, the country will receive 1 vote per affiliate, up to a maximum of 5 votes, irrespective of whether or not that country is comprised of more than 5 affiliates.

Affiliate news

We welcome your news, ideas and queries. We invite you to contact us with a brief update of an event, an exciting project that you are part of, or an ongoing issue that is of particular concern to your affiliate. It is always great to hear from you and to be able to share your experiences with other affiliates.

Perspectives from Masters and Doctoral Students

By Angela McLaughlin, University of Edinburgh, Scotland

E-mail: s1152158@exseed.ed.ac.uk

This column focuses on the perspectives of clinicians/students who are engaged in infant mental health research at Masters and Doctoral level. It features a sample of current ethically approved research projects. The column aims to highlight the diversity of student research across the globe that is being conducted by WAIMH members, while also providing a global community of interest and support for each student's research.

If you are a WAIMH member/WAIMH student member who is currently engaged in Masters or Doctoral research, and you have ethical approval for your study, we invite you to share a little bit about your study. This would entail providing the following:

1. Project working title;
2. Name of your institution and department;
3. Name/s and institutions of your supervisors; and
4. A working abstract about your research.

This column features two current doctoral research projects. The first project overviewed here is research being conducted by Ms S. Christine Bartram, The University of Warwick, Medical School, Division of Mental Health and Wellbeing, Coventry, UK. The second is being conducted by Angela Lisa McLaughlin (University of Edinburgh). Angela is in the final year of her PhD in Clinical Psychology. Her research was presented as a poster at the World Association for Infant Mental Health's, World Congress (Edinburgh, 2014).

Title: The Neonatal Behavioral Assessment Scale (NBAS) for supporting caregivers and newborns in Keneba, the Republic of the Gambia: development, piloting and feasibility

Doctoral Researcher: Ms S. Christine Bartram, The University of Warwick, Medical School, Division of Mental Health and Wellbeing, Coventry, UK.

Email: S.C.Bartram@Warwick.ac.uk

Researchers at the MRC unit in Keneba (Republic of the Gambia, West Africa) are interested in using newborn behavior to evaluate the impact of early nutrition on infant cognitive development, but do not currently have a standardized tool available to assess infant behaviour during the neonatal period. This project aims to assess whether the Neonatal Behavioral Assessment Scale (NBAS) can be used with caregivers and infants in Keneba in a way that is acceptable, relevant, and desirable to the community.

The research involves four objectives, in line with MRC guidance for developing and evaluating complex interventions.

1. Development: Systematic Review. To conduct a Cochrane systematic review to examine the NBAS's evidence base and to identify moderating factors.
2. Development: Contextualization. To conduct field observation in order to contextualize the project in terms of Keneba's religious, cultural, and socioeconomic context, and to conduct semi-structured interviews (N = 30) to understand the experiences, goals and concerns of caregivers regarding themselves and their families, as reported by caregivers, paediatricians, and other community members, in order to determine whether the NBAS is likely to be relevant to caregivers and infants in the community.
3. Piloting. To train two local staff to deliver the NBAS. To conduct a qualitative pilot study to assess receptivity to the NBAS, including pilot sessions with caregiver-infant dyads (N = 10) and two focus group discussions (N = 10 caregivers, N = 5 community members) regarding relevance and acceptability, and to suggest whether any modifications to the NBAS are needed for this context.
4. Feasibility. To conduct a feasibility study of the NBAS as an intervention for improving caregiver and infant outcomes, namely, survival.

The project has been given funding and UK ethical approval; it is currently being considered for local (Gambian) ethical approval. The Cochrane protocol is pending publication and fieldwork is set to begin in March, 2015.

Supervisors:

Prof Jane Barlow. The University of Warwick, Medical School, Division of Mental Health and Wellbeing, Coventry, UK.

Prof Dieter Wolke. The University of Warwick, Medical School, Division of Mental Health and Wellbeing, Coventry, UK.

Title: THE BUTTERFLY EFFECT: Examining the impact of multiple adversities upon neurodevelopmental and attachment trajectories from foetal beginnings until infanthood

Doctoral Researcher: Ms Angela Lisa McLaughlin. University of Edinburgh, Scotland, UK.

She can be contacted by email at: s1152158@exseed.ed.ac.uk

Multiple adversities during the perinatal period poses real risks for mother and baby, yet little is known about the impact that such exposures have on early neurodevelopment and attachment. This PhD research, code-named Project Butterfly, is a prospective exploratory study asking the principle question: *Can a Butterfly Effect be observed in the neurodevelopmental and attachment trajectories of babies exposed to multiple adversities from womb to cradle?* These include exposure to: drugs (illicit, legal or prescribed), gender-based violence, inadequate nutrition, infectious diseases, maternal illness, maternal mental ill-health, poor social support, poverty, stress and trauma.

This research aims:

1. To explore the neurodevelopmental trajectories of babies exposed to multiple adversities in utero and during the first four months of extrauterine life;
2. To explore the attachment trajectories of dyads exposed to multiple adversities during this time;
3. To explore whether the type, timing and frequency of the adversities experienced leads to differing neurodevelopmental and attachment trajectories observed.

Project Butterfly will adopt a case series analysis using a mixed methods approach informed by Grounded Theory methods. Neonatal Behavioral Assessment Scale examinations will be conducted at birth and six weeks postpartum followed by a Bayley III assessment at four months. CARE-Index video footage, at six weeks and four months, maternal interviews and a range of questionnaires will also be used to gather dyadic data from pregnancy to four months postpartum. These methods will be utilised to track the neurodevelopmental and attachment trajectories of babies exposed to multiple adversities in utero and during the first four months of infant life.

Data collection for this PhD project has now been completed. The Doctoral Thesis will be submitted and defended later this year.

Ethical approval has been granted by the University of Edinburgh and NHS Forth Valley.

Supervisors:

Dr Ethel Quayle, Senior Lecturer in Clinical Psychology, University of Edinburgh.

Mrs Sheila Atalla, Health Visitor, NHS Forth Valley.

Prof Matthias Schwannauer, Head of Clinical and Health Psychology, University of Edinburgh.

If you would like to learn more about my PhD research, my work through the Butterfly Baby Clinic; which I established through my PhD journey (www.ButterflyBabyClinic.com) or would like to connect I would be delighted to hear from you.

Moving Away from WEIRD: Systems-Based Shifts in Research, Diagnosis, and Clinical Practice

By Connie Lillas

Director, Interdisciplinary Training Institute

Specializing in training cross-disciplinary teams in national and international communities

Pasadena, California, USA

infantmentalhealth@earthlink.net

and

Mary Ann Marchel

Associate Professor in Early Childhood Studies and Social Work
University of Minnesota Duluth, USA

mmarchel@d.umn.edu

In 2000, the World Association of Infant Mental Health (WAIMH) Handbook (Vol. 1) described *the infant mental health (IMH) field* as a "relatively young" … one engaged in a process of defining, evolving, and expanding itself (Fitzgerald & Barton, 2000, pg. 4). In this same seminal chapter, IMH was *contextualized* as being influenced by the theoretical forces of evolutionary, systems, and psychoanalytic theories. Each of these is implicitly a developmental theory that attempted to account for behavioral change over time. IMH was *defined* as holding multiple levels within its purview. This ranged from being an educational discipline, to a clinical field, to a research discipline. Collectively these levels coalesced around the social and emotional dynamics of infants and their caregivers. Important in this endeavor was the necessity of IMH being multidisciplinary and international, with the promise of emerging as an *interdisciplinary field* (Fitzgerald & Barton, 2000).

In this context, increasing concerns regarding cultural diversity and disparity were also emerging. It is important to note that within this same WAIMH chapter in 2000, it was recognized that a disproportionate amount of United States-based authors across all major scientific data bases existed. While there was some degree of diversity represented within the Infant Mental Health Journal (IMHJ) at this time, IMHJ declared a concerted effort towards shifting this disparity. In fact, the remainder of this WAIMH Handbook's eleven chapters in Volume 1 (Fitzgerald & Osofsky, 2000), was dedicated to this very issue of demonstrating multicultural issues within infant mental health, representing 13 different countries. Staying true to its vision, and in sharp contrast to other scholarly and developmental journals involving infant research, the IMHJ showed an increase of 42% in its inclusion of population samples outside the United States or studies with infants of color from 2002 to 2006 (Fitzgerald, 2006).

Fifteen years later, we pause to reflect and survey the contextual landscape that surrounds the now "older and more mature" IMH field. We take a macro level viewpoint that looks at the continued influence of dynamic systems theory upon research and diagnosis; global concerns about cultural disparities from other lenses; and several National Institute of Health (NIH) and National Institute of Mental Health (NIMH) shifts (albeit from the United States) that reverberate and support the IMH field. Challenges to traditional research assumptions and practices with their influence on diagnosis and clinical practice have become even more prevalent in the last five to seven years.

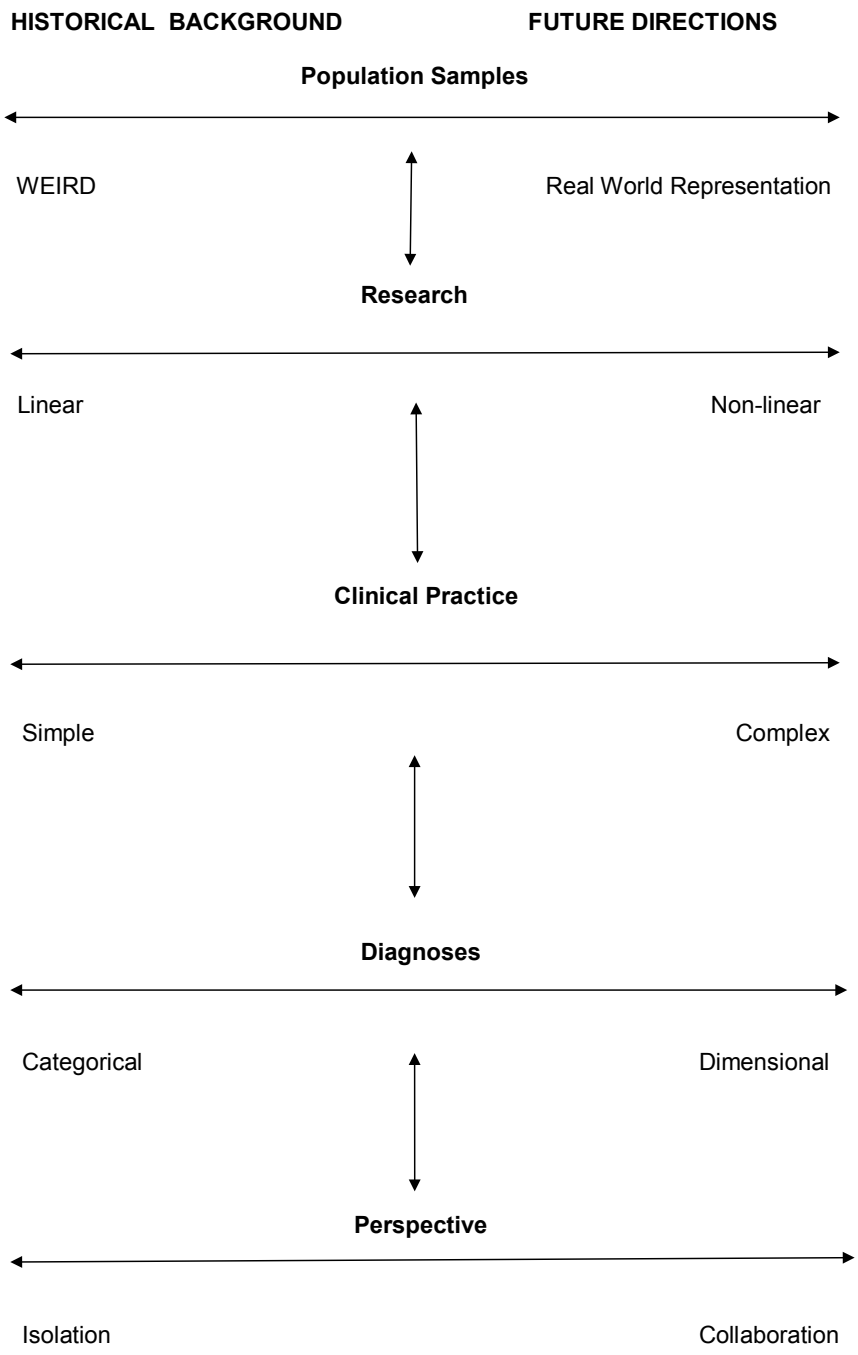
In this paper we briefly review emergent concerns and how they have led to prominent shifts in the United States research community that may very well affect the international research community. These "top-down" NIH research shifts have short- and long-term implications for clinical practice, which continue to strive toward application to the real world populations being served. The drive from the "bottom-up" clinical community in-turn contributes to a bidirectional influence in moving research toward the same direction IMH has already claimed as its own – toward relational complexity. The field of IMH indeed continues to evolve and mature. As a field, we have been aware and a part of these shifts long before these have become national or world-wide movements. As a result, we are poised to participate in the current shifts in research and diagnosis unfolding across larger contexts with increased momentum. Our maturation will exponentially propel us further into new ventures of interdisciplinary collaboration.

Parallel Processes with IMH and Large Scale Research Movements

There are several large-scale concepts that the research community has acknowledged as concerns. We see this as a type of parallel process with many shifts the IMH field has already made. We will focus on the following shifts, adding more detail as the article progresses. 1) It has become increasingly evident to the larger research community that cultural and fiscal disparities reside with current population sampling strategies on a world-wide level. 2) It has become increasingly clear that that the use of diagnostic categories misalign with the clinical complexities of underlying systemic dimensions, dismantling the use of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for research purposes and replacing it with NIH research domains since 2013. 3) It has become increasingly obvious to the NIH that there are limitations to linear research methodologies [even though systems theory has been around since the 1930's (von Bertanlanffy, (1968); Sander (1987); Gottlieb (1991); Fitzgerald & Levine, 1992; Thelen & Smith (1994);Tronick, (2007), with many others, beyond the scope of this brief article, involved in the shift to systems approaches].

In recognition of the valuable application of systems theory to research, the NIH, Centers for Disease Control and Prevention, the Institute of Medicine, and many others (Mabry, et. al, 2013) have required adding nonlinear dynamic systems science methodologies to federal grants since 2009. It has become increasingly acknowledged that isolated research laboratories can no longer solve the complex problems we face. Hence the NIH Roadmaps emphasize the employment of translational, interdisciplinary, and community-based participatory research approaches.–All require an increase in collaborative efforts across disciplines and a shift from laboratory isolation to community involvement. As we review these items, we suggest that these are all part of an interdependent ecosystem comprising the "Parallel Process of Shifts in Research Perspectives that Enhance Clinical Practice" (see Figure 1). Similar to the parallel process model often applied to work in reflective supervision (Heller &

Figure 1. Parallel Process of Shifts in Research Perspectives that Enhance Clinical Populations.



Gilkerson, 2009; Heffron & Murch, 2010), this parallel process model proposes that movement or shifting within or across layers impacts and reflects the status of the other levels. The strength and viability of each layer is interdependent on and impacted by the variability, sensitivity, and responsiveness of their counterparts. As we explore the mismatches between current research and diagnostic approaches and their incongruence with the "real (clinical) world," we hope to demonstrate that outside of the field of IMH there is a more recent push to move from the simple to the complex, from the linear to the nonlinear, from the categorical to the dimensional, from the laboratory (isolated) to the community (collaborative) –all embedded within a dynamic systems framework. We propose that as clinical theory, research, and practice in IMH has accepted a dynamic systems approach years ago, a growing parallel process has occurred within the Social and Behavioral research community on a larger scale. We are hopeful that as these "bottom-up" clinical and "top-down" research levels further promote dynamic systems theory, practice, and research on a much grander scale, that IMH, as an already existing interdisciplinary field, will make use of these shifts, coalescing into a stronger, wiser, more solid work force around the world.

World Perspective of Mismatched Populations

The basis for most of the world's top research journals comes from population samples drawn from "Western, Educated, Industrialized, Rich, and Democratic (WEIRD) societies" (Henrich, Heine, & Norenzayan, 2010). The inherent assumption in using this narrowly defined group is that this group is representative of the rest of the species, and research findings are generalizable to the rest of the world. However, in Henrich et al.'s (2010) review of comparable data bases across the behavioral sciences, the WEIRD subjects, rather than being representative of other world cultural groups, were actually rated as "frequent outliers" in many domains including essential features of motivation, psychology, and behavior, especially with reference to young children. Thus, what is often perceived as a "dominant" cultural group producing top-notch research that is applicable to all, is actually mismatched, not truly representative of the larger reality that exists from a global perspective. Representation of the "real world" population is further complicated by the historic distrust in research and health care existent in many underserved populations (Freimuth, Quinn, Thomas, Cole, Zook, & Duncan, 2001; Gamble, 1993). Additionally there is a mismatch between Euro-Western worldviews (upon which current academic research traditions are founded) and those of marginalized and oppressed groups that comprise groups who are served or who are in need of services (Chilisa, 2011).

As aforementioned in this article, the historical trajectory of research efforts in the field of infant mental health have considered and responded to the gaps potentially created by the WEIRD phenomenon (Fitzgerald, 2006). Therefore, we are positioned to join and contribute to current research efforts that encompass the real world population. However, as we move toward future research efforts, disparities still exist with non-Western, unindustrialized societies. Therefore, continued awareness of disparities existent between the representation of population samples and the real world population is essential.

Mismatched Populations in the WEIRD World

When we turn to concerns and challenges even from within this thin slice of WEIRD humanity, similar concerns about laboratory research being based upon mismatched populations have also been clearly voiced. Multiple types of mismatches have been documented between laboratory research settings and community practice. All the while, however, with these inequities in place, it is common for research laboratories to place their stamp of approval on the growing group of "evidence-based" treatments (EBT) documented as applicable to the "real-world," even though they are often based on a population within the WEIRD world that does not match the at-risk and high-risk populations within any given community. These discrepancies will become more apparent as we continue the discussion below.

First, relatively simple, and often less complicated and less complex cases (e.g., singular diagnostic criteria that assumes a single causal pathway), that have been easiest to contact or those most compliant to come to hospital or laboratory based settings have been the source of both developing and testing "evidence-based medicine" and "evidence-based social science" treatments (Herbert, Brandt, Armstead, Adams, & Steck, 2009). In addition to this being somewhat tautological, the populations often studied for disease processes are often not representative of ethnic and economic minorities.

Similarly, from the social science side of research, infants and young children most often get into a particular study based on singular diagnostic categories, as most EBTs are diagnostic specific. The contradiction is that a singular diagnostic category is not the norm in community health/mental health settings. Rather, co-morbidity across more than one diagnostic category, often increasing with degree of severity and family adversity, is the norm (Weisz & Gray, 2008). Not too long ago, an esteemed university in California came to a well-known community-based mental health clinic looking for singularly depressed 3-year olds. This clinic is located in South Central Los Angeles –zip codes holding a very at-risk population of infants and young children in Los Angeles. With high risk of co-morbidity and complex trauma, how many subjects could participate in this EBT study for depression? In reality, none.

In a more formal review of the literature, Weisz, Doss, and Hawley (2005) reviewed how research studies are conducted, identifying clinical versus non-clinical dimensions, and found the following concerns. Across dimensions of clinic settings versus research university settings, actual practicing clinicians versus graduate students or research-employed therapists, and actual treatment-seeking clients versus children recruited for efficacy trials, "only 1% of the studies reviewed included some clinically referred children, with at least one practicing clinician, with some treatment carried out in a clinical service setting" (Weisz, et al. 2005, p. 59, italics added). Thus, from this particular review, within the WEIRD and EBT worlds, 99% of research conducted is based upon 1% of an actual clinical population. In summary, EBTs are often based upon research done with singular variables (singular diagnosis), conducted by non-clinicians, and in non-clinical settings. What further complicates matters is that EBTs are also accompanied with, most often, a rather rigid set of manualized and prescribed interventions that have little respect for the time it might take to build rapport and a therapeutic alliance. Similarly, they rarely account for individual differences, nor accommodate spontaneous events that occur within the child or family system (Weisz & Gray, 2008). Subsequently, there is little room to tailor the EBT to the actual population being served.

Evidence-based practice, in its original definition from the Institute of Medicine, requires a three-pronged process of weighing and juggling the following variables: (a) the best of what research provides (this includes the EBTs); (b) the best of professional wisdom based upon theory and years of clinical practice; and (c) informed consent from parents, matching the family's culture and needs (Sackett, et al, 1996; Buysee & Wesley, (2006); Brandt, Diel, Feder, & Lillas, 2012; Lillas, Feder, Diel, Brandt, 2014). In contrast, it is assumed that if one is using an EBT, that s/he is conducting an Evidence-Based Practice (EBP). These terms are often conflated and have become synonymous with each other. Thus, in many situations, EBP becomes a rote application of an "evidenced-based treatment" without the use of clinical wisdom that matches the neurodevelopmental needs of the children and parents with the type of EBT offered. Ideally, there would be an inclusive "menu" of treatments, with both bottom-up and top-down neurodevelopmental applications that could be matched with the needs of the child, parents, and family system (Lillas & Turnbull, 2009).

The Parallel Process: Shifting from Simplicity to More Complexity

Building upon this inequity between research populations and clinical populations within the larger research world, we see three parallel processes that bring much needed transformation that will affect clinical practice. Essentially, these changes are dedicated to expanding to accommodate heterogeneity (individual differences) and complexity. The earlier discussion of restricting research studies to singular diagnostic categories and the associated challenges demonstrate the need for these shifts. For example, within early childhood, all too often we have the diagnosis of "autism" as the primary diagnosis defined in one categorical system (e.g. education, in United States legislation, Part C of the Individuals with Disabilities in Education Act) and "trauma" or "post-traumatic stress disorder" as the designated diagnosis for mental health providers. In many fiscal systems, the categories of developmental delays and mental health emerge from bi-furcated funding streams, which in turn support fragmentation and health care that is siloed. Even if the funding is not compartmentalized, the diagnostic categories often are, and these diagnostic "camps" operate without a common framework or shared approach. These are false dichotomies, and the dynamics reviewed here reveal more about these inaccuracies that are now being caught and challenged.

Parallel Process: Shifting from Categorical to Dimensional Perspectives Within Diagnoses

A few weeks before the long-awaited Diagnostic and Statistical Manual of Mental Disorders V (DSM) was released in May, 2013, a seismic shift occurred when the National Institutes of Health (NIH) and Mental Health (NIMH) both announced that they would no longer be funding research based upon DSM criteria (Insel, 2013). Whereas having a common language through the DSM or the International Statistical Classification of Diseases and Related Health Problems (ICD-10) has been useful, the criticisms are rooted in the fact that these manuals are organized around symptom-based categories that reflect an outdated view of how the mind, body, and relationships work. By analogy, they offer a symptom

checklist approach to assigning diagnostic value. This is akin to practicing medicine by creating diagnostic categories and treatments based solely upon the symptom of a fever or the subjective type of chest pain, rather than referring to objective laboratory measures that now exist across many levels – such as genetics, molecular and cellular biology, imaging studies, neural circuitry, physiological activity, cognitive science, and other levels of information based in brain-behavioral relationships (Insel, 2013) and NIMH (nd), retrieved February 5, 2015).

The goal of this next decade is to collect new data based upon a framework of Research Domain Criteria (RDoC), beginning with five domains of functioning: (a)positive valence systems, (b) negative valence systems (e.g., positive and aversive motivational systems), (c) cognitive systems, (d) systems for social processes, and (e) arousal/modulatory/ regulatory systems. These domains are intended to be a starting point and are not set in stone. These realms can be then studied across different classes of variables –from genes, molecules, cells, neural circuits, physiology, behavior, and self-report. The long-term goal is to transform how diagnoses are made, with much more specificity and complexity, and eventually, to offer the right type of treatment(s) matched with much more specificity and complexity. In order for transformation to occur, a change from current funding practices that recognize the DSM and ICD-10 as the "gold standards" is essential.

In addition, the critique of the DSM process of categorization observes that many of the "same" symptoms can be found in multiple DSM diagnostic categories, and large categories, such as "depression", carry very little specificity, lacking an awareness of individual differences. In this regard, there is a fundamental shift to looking at underlying dimensions that may cut across multiple DSM diagnostic categories. This dimensional shift is dedicated to looking at a full range of typical to atypical ranges of behavior. How clinical sample research populations will be garnered will also change to include a much wider range of constituents. Thus, a shift will occur away from the narrow requirement of having only a singular diagnosis in order to get into the study, and subjects will intentionally include more diagnostic complexity as well as "more clinical settings " (Cuthbert & Kozak, 2013, p.930). For example, all clients across a range of "mood disorders" within a clinic setting may be studied rather than only those meeting criteria for a strict, single major depressive episode.

In the field of IMH, there is an ongoing urgency to reduce the disparities gap existent for low socioeconomic, rural, racial, and ethnic minority populations in the access to appropriate services. We are hopeful that shifts towards more specificity and complexity in the diagnostic realms will continue to address this issue with increased momentum. Similarly, research paradigms that address the complex and dynamic nature of this work are essential to the maintenance and continued growth of our field.

Parallel Process: Shifting From Linear to Non-linear (Systems Science) Research Methodologies

As specificity and complexity gather momentum in the diagnostic world of research, research methodologies that can hold complexity and specificity at the same time also gather momentum. Systems theory is an intellectual theory and research paradigm often associated in its origins with Austrian biologist Ludwig von Bertalanffy (1968). Clinical examples include family systems theory as well as incorporating an understanding of biological systems. While dynamic systems approaches have carried more weight in engineering, aeronautics, and biology, a slow and steady growth over the last few decades has evolved to include medicine, social and behavioral sciences, and public health (Mabry, et. al., 2013).

Part of this shift has come from a growing consensus that the social and behavioral sciences have relied on traditional linear research methodologies that typically narrow the problem, isolate variables, and use linear analytic representations. Linear models will continue to be useful and are necessary. However, it is increasingly recognized that research methodologies that hold more complexity, nonlinearity, interactive phenomena, bidirectional feedback loops, multiple causation, and time-delayed effects are essential in order to deal with more complex phenomena (Mabry & Kaplan, 2013; Mabry, Milstein, Abraido-Lanza, Livingood, & Allegrante, 2013).

In conjunction with this paradigm shift, technological advances have made systems modeling and simulation methods more accessible to the average research investigator. NIH has made significant investments in the use of systems methodologies for large-scale medical disease processes (e.g., cancer, obesity, diabetes), and these models are now moving into the social and behavioral arenas. Systems models are increasingly a part of the NIH federal grant requirements, with NIH's investment in financing systems methodologies from 2009 to 2013 coming to a grand total of $35.4 million for 91 projects (Mabry & Kaplan, 2013). This is a significant investment surge "considering that prior to 2008 there were no NIH funding announcements for the behavioral and social sciences that were focused on systems science" (Mabry & Kaplan, 2013, p. 11S).

System methods aim to enhance understanding about real world systems, affording translation of evidence into practice, often through the generation of computational models. Three specific methods have been applied to real world problems in social and behavioral sciences, and are highlighted in the literature (Burke, et al., 2014). Systems dynamics modeling potentiates the capacity to frame, understand, and discuss challenges embedded in complex system. Agent based modeling employs computational methods to examine environments (e.g. communities) and agents (individual community members) situated within. In network analysis, the relationship between a set of nodes (e.g. community members and organizations) are examined and can be used to track relational changes in direction (unidirectional/bidirectional) and the "thickness" of social relationships within family and community settings.

In conclusion, systems thinking pushes us to replace narrow, reductionist, static, and short-term views of individuals, relationships, communities, diagnostic formulations of health/disease, and treatment interventions with broad, dynamic, and complex perspectives that take into account multiple considerations. Thereby, the complexities and interdependencies of the real world become incorporated into the research models.

The Parallel Process: Shifting to Translational and Interdisciplinary Perspectives

Several initiatives have attempted to reduce the gap between the promise of evidence based mental health practices and the realities of community practice. The NIH Roadmap for Medical Research (as cited in National Institute of Health, 2014) speaks to both the need for translational and interdisciplinary research. From one angle, NIH asserts that "in order to improve human health, scientific discoveries must be translated into practical application.

Such discoveries typically begin at "'the bench'" with basic research –in which scientists study disease at a molecular or cellular level-then progress to the clinical level, or the patient's bed side" (as quoted in Herbert, et al., pp. 1214, 2009). When considering the application of translational research in IMH, this bench-to-bedside approach extends into whole communities and populations. In order to reap the benefits of scientific discoveries, findings must be available to all communities in a shared language. A research orientation such as this promotes a partnership between "researcher" and community "participants." The partnership is undergirded by shared power, inclusivity, and the recognition of multiple forms of knowledge (Minkler & Wallerstien, 2010). Hence, research becomes a shared tool that empowers communities to explore solutions to mitigate disparities and gaps that exist in mental health care.

From another angle, and within a similar process of creating increased links, NIH describes health research as commonly being organized "much like a series of cottage industries, lumping researchers into broad areas of scientific interest and then grouping them into distinct, departmentally based specialties" (p. 1214, as cited in Herbert, Brandt, Armstead, Adams, & Steck, 2009). Recognizing the fragmentation of this siloed approach, NIH acknowledges that researchers will have to move beyond the confines of their own disciplines and foster shifts in academic culture to create collaborative models for team science (NIH Roadmaps, 2014).

Considered together, movement toward participatory-translational and interdisciplinary perspectives hold promise in significant reduction of disparities in health status existent between the WEIRD and real world populations. Further, the opportunity to work across disciplinary and academic /clinician silos is essential to unification of a currently fragmented system. Rather than working in isolation, we envision the adoption of a collaborative perspective (see Figure 1) in which researchers, clinicians, and communities operate in synchronicity. Shared knowledge and expertise is exchanged and co-created, then used as a tool to address the issues and challenges that exist within the lives of young children and their families. We now explore these orientations.

Translational research

Translational research is intended to "translate" or move basic research discoveries into practical application. Occurring across a continuum (Dankwa-Mullan, et al., 2010), translational research is bidirectional, cyclical, and includes the following domains: (a) basic science discovery; (b) testing and application in developmental stages; (c) outreach and dissemination of findings, and (d) adoption and implementation. Although the domains appear in linear progression from discovery to dissemination, translational research harnesses the value of findings as they emerge (e.g. during outreach and dissemination) and allow their application to discovery and development.

Interdisciplinary research

In addition to the recognition of translational research model, the NIH advocates interdisciplinary approaches as a means to mitigate gaps existent between traditional approaches and "real communities" and to respond to the dynamic process inherent in the complex study of humans. Interdisciplinary approaches allow for intellectual exchanges across disciplinary boundaries. Shared expertise allows greater effectiveness in harnessing the collective power of individual strengths to solve "real problems." Hence, we must move away from antiquated approaches that group researchers into distinct, departmental based specialties. Rather, it is incumbent upon researchers to keep pace with scientific discovery through implementation of an interdisciplinary lens. Current NIH initiatives support interdisciplinary training and the creation of specialized centers. Initiatives such as this support, with translational research, a shift toward decreasing the mismatch between traditional research practices and the real world. More specifically, research orientations that engage the expertise of community members as partners in addressing and understanding "real problems" suggest a compatible approach to minimize disparities and closing gaps. Community Based Participatory Research illustrates a research approach applicable to the creating meaningful and sustainable change and will be addressed further in upcoming Perspectives in IMH issues.

Recommendations

Mismatches and parallel processes co-occur across multiple layers and levels of clinical science and practice. We have covered a range of them –from an international perspective, to a US/ industrialized perspective –along with important shifts that offer some correction to these concerns. We inherently see these shifts as part of that double feedback loop process that is changing and challenging our existing mental models and frameworks, taking us further down the road into complexity and collaboration. We offer the following recommendations:

1. Be a responsible consumer of EBTs; notice the exact population, setting, and types of providers offering the EBT.
2. Become an advocate for families in communities being offered EBTs that have evolved from subclinical mismatches and disparities.
3. Even with EBTs targeted to actual high-risk clinic populations, not all were found to be superior in outcomes to "usual care" being offered. Do not disregard "usual care" as an anomaly but include it in an expanded data base and treat it with respect and as part of the informed choice families have (Weisz & Gray, 2008).
4. Support community-based orientations in research. Get involved on a ground floor level as a practitioner working in a community setting, working with real-world families that have multiple problems and co-morbidities.
5. Use frameworks that hold multiple causalities, cut across diagnostic categories, and shed light on underlying neurodevelopmental processes and dimensions.
6. Accept the challenge to work across silos. Move away from disciplinary fragmentation into interdisciplinary work –whether on an academic, research, or clinical level.

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Travel report from Fukushima, Japan

By Kaija Puura, Associate Executive Director of the WAIMH, Tampere, Finland

E-mail: Kaija.Puura@pshp.fi

When we hear the name Fukushima, most of us probably remember the triple catastrophe of a strong earthquake, huge tsunami wave following it and the terrible accident in the nuclear power plant that took place on March 11th, 2011 in the Tohoku area in Japan. As a consequence of those disastrous events over 18 000 people died or went missing, and a huge number of families were forced to relocate from their homes to other areas because of destruction of their homes or nuclear radiation pollution. I had the honour of visiting the Tohoku area in 21st - 24th November 2014, to give a lecture in the national Four Winds Congress in Kooriyama and attending the first annual board meeting of the WAIMH Japanese Affiliate. Three and a half years after the disastrous events, what struck me first when arriving to Kooriyama was how normal everything looked: the city was busy, people were going about their business and sun shone on a beautiful autumn day. For my first day my host, Professor Hisako Watanabe first took me to see a thing I have not seen anywhere else: an indoor playground with big areas of sand and water where children could play as if they were outdoors, lots of air-filled mattresses for running and jumping, and little kitchens where children could learn to cook healthy snacks for themselves. This was the PEP Kids Kooriyama, a playground that was funded by a private entrepreneur who donated it to the city. The playground opened for Christmas 2011 where children could play for free. Since its opening, 1,000 000 children and their parents have played in PEP Kids.

Professor Watanabe had also organized for me a trip to the countryside, to the smaller town of Date. On that trip, riding across the countryside by train and car, I noticed the first signs of being in a disaster area: radiation meters by the roads and men at work, peeling the topmost layer of the earth and storing it into big plastic containers that were piled by the roadside. In Date I met Mrs. Kanae Narui, clinical psychologist of the NPO Heartful Heart for Nuturing the Future, community nurses and an occupational therapist of the Date Health Care Center. Mrs. Narui kindly let us observe while she and her team attended to a group of local ladies aged from 75 to 85 years.

Mrs. Narui (in the middle on the right side) with her team.

What I saw was a brilliantly led group intervention. I also learned how far reaching the consequences of the disaster still were. Almost all younger families had left the area in 2011 and were afraid to come to visit their parents, thus making it impossible for these grandparents to see their grandchildren. The loss of their children and grandchildren and the prospect of not having anyone to continue the farming was causing health and family problems for many of the women. The session ended with a hilarious session of laughter yoga that we visitors were also allowed to take part in. Laughter yoga has a simple principle: you make laughing sounds like hahaha or hohoho, clap your hands together in the same rhythm, and when you do this while also making eye contact with another person you cannot but start laughing for real. It certainly does not make any difference where you come from, how old you are or what language you speak: shared joy is something that unites us! On our way back to Kooriyama we also drove through a ghost town that had been abandoned due to high radiation levels, where only beautiful houses, library and schools now stood empty. While we drove back we also saw a group of children singing Christmas carols beautifully – later I heard it was the first time in three years that they had been able to do that, as the recommended time spent outdoors had now become unlimited.

In the Four Winds National Congress I felt that I learned more about trauma and resilience than I was able to teach with my own lecture. I was most impressed by how the local professionals from every possible field from engineers to teachers, health care professionals to parents, business men and workers had worked together through the years after the disaster to build a healthy and sustainable community for the children. In the Fukushima area Dr. Shintaro Kikuchi had been the leading force in organizing services that the children needed. In the Miaygi district Dr. Hiroaki Homma had done a huge task in organizing mental health services for children and families. In the Iwate district Dr. Hiroko Suzuki had recognized the specific posttraumatic symptoms caused by earthquake in children and parents, and organized care for treating them.

Throughout the Congress the local professionals described creative and effective solutions for treating traumatized children, ranging from health promoting solutions for providing exercise and fun to children to group interventions in day care centers and schools. The fact that many health care professionals also lost their lives in the disasters made it imperative to create more and long standing co-operation between health care professionals, day care personnel, teachers and parents. What I also learned is that the best way of gaining people's trust and confidence in the services offered is to work through the local, familiar staff. A good example of this was Professor Watanabe's own approach: by contacting

local professionals like Dr. Kikuchi and Mrs. Narui she was able to offer her support to them and to other professionals in the area, which resulted in a series of beautiful, knowledge based interventions for treating psychological trauma for younger and older children, for parents, and as in Date, even for grandparents.

But what about the future of the children and families in the Tohoku area? The catastrophe still continues to cause harm, as adults are torn with guilt about leaving their home towns and with uncertainty regarding whether it is safe to return or better stay in the area where they had been relocated. The shadow of the fear of radiation is still big and dark, even though according to the local newspaper the radiation level in Kooriyama was lower than in Tampere, my hometown! After three years the acute traumatization has ceased, but as Dr. Homma has reported, the problems caused by untreated traumatic experience have made it difficult for people to cope with everyday stress and children are not doing as well as they should. Dr. Hiroko Suzuki also pointed out quite rightly that struggling to cope with other people's needs on a daily basis has started to wear out the professionals who are showing signs of compassion fatigue. It is clear that both the families in the Tohoku area and professionals working with them need support for many more years to come.

Perhaps the WAIMH Affiliates and WAIMH as a global community of infant mental health specialists could also do their part by offering training and professional consultation or supervision to help and support the local professionals with their task – in Japan and also elsewhere in the world where the need arises. Maybe it would benefit us all to go and learn from our colleagues who cannot wait for the perfect service or therapy, but have to try and help with those resources they can spare.

I will end with a quote, a part of the Hana wa saku – the Flower Blooms - a song the Tohoku people made to remember all those who died. With it I wish to honour and thank all the wonderful people whom I met during my trip to Fukushima.

Dr. Shintaro Kikuchi, Professor Koji Kato and professor Hisako Watanabe with Kaija Puura at the Four Winds Congress In Kooriyama.

Darekano utaga kikoeru	*I hear someone's singing voice*
Dareka o hagemashiteru	*cheering somebody*
Darekano egaoga mieru	*I see someone's smile*
Kanashimino mukou gawani	*beyond our sorrow*
Hanawa saku	*Flowers bloom*
Itsuka umarerukimini	*For you who will be born in the future*
Hanawa saku	*Flowers bloom*

Watashi wa nanio nokoshita darou? What did I achieve and leave?

From the Field: Infant Mental Health Journal

The Michigan Association for Infant Mental Health and WAIMH invite you to consider subscribing to the world renowned Infant Mental Health Journal, reflecting the interdisciplinary nature of the infant mental health field and an international focus through research articles, literature reviews, program descriptions, clinical studies, and book reviews. Below is an abstract of one article from the first issue of this year:

Through the Eyes of a New Dad: Experiences of First-Time Fathers of Late-Preterm Infants, Infant Mental Health Journal , Vol. 36(1), 78-87 (2015)

By Karen M Benzies, University of Calgary, Canada and Joyce Magill-Evans, University of Alberta, Canada

ABSTRACT: Fathers of late-preterm (34–36 weeks' gestation) infants may experience challenges in parenting. Late-preterm infants are more irritable. The unexpected early birth of an infant may negatively affect fathers' cognitive and emotional experiences. The Father–Infant Interaction Program (FIIP) is a video-modeled play intervention that aims to increase fathers' sensitivity and responsiveness to infant cues. Using data from a larger randomized controlled trial (RCT) to evaluate FIIP, the purpose of the present study was to explore the experiences of first-time fathers of late-preterm infants and their perceptions of the intervention. We conducted semi-structured qualitative interviews with 85 fathers of 8-month-old infants during the outcome home visit for the RCT and thematically analyzed data. Three main themes about fathers' experiences emerged: Fathers believed they had the "best job in the world," yet saw fathering as the "biggest job ever." Fathers viewed fatherhood as an opportunity for personal growth and reflected on how their lives had changed since the arrival of their infant. Fathers in the intervention and comparison groups liked the convenience of the home visits and validation of their role as a father. Fathers in the intervention group liked the tailored feedback about play.

For a limited time only, we have received permission to download this one article as a sample of what the IMHJ contains.

For a one-year subscription www.WAIMH.org under membership.

Author guidelines for Perspectives in Infant Mental Health

- APA, sixth edition, for style
- 12 point font
- Double spaced
- 250 words per page
- Articles of varying length are welcome, however, length should not exceed 15 pages Word-format
- Send pictures and tables in separate files, with a resolution of at least 72 pixels/inch
- Manuscripts are accepted throughout the year
- Articles much shorter than 15 pages are also welcome for submission
- Articles from the field must be submitted for review by April 15, 2015 in time for the Spring Issue of Perspectives
- Send the submission to:

  Deborah Weatherston,

  dweatherston@mi-aimh.org

From the Kauppi Campus

-News from WAIMH Central Office

By Pälvi Kaukonen, Executive Director, Tampere, Finland, ed@waimh.org,

Kaija Puura, Associate Executive Director, Tampere, Finland, congress@waimh.org and

Minna Sorsa, Administrative Assistant,Tampere, Finland,

office@waimh.org

Dear colleagues,

Year 2014 was another successful year for WAIMH. We had a fruitful and vibrant World Congress in Edinburgh, where delegates from 60 countries met and formed networks with each other for strengthening infant mental health activities. The world of WAIMH is now wider than ever. Currently our members include 985 Infant Mental Health specialists from 45 countries (see Figure below).

Most of our members originate from the United States (356). Australia has 125 and Canada 77 members. Japan has one of the newest WAIMH Affiliates and altogether 52 persons were members of WAIMH in 2015. In Europe we have members in United Kingdom (60), Norway (32), Finland (28), Germany (23), France (20), Netherlands (19), Switzerland, Italy (18), Sweden (17), Ireland (14) and Denmark (13). We also have members in New Zealand (17), Israel (10) and South Africa (10). All the other 27 countries had less than 10 WAIMH members in 2014.

15th World Congress in Prague

The 15th World Congress of WAIMH will be held in beautiful Prague in the Czech Republic on May 29 –June 2, 2016. The Local Organising Committee, WAIMH Central Office and Programme Committee have started their work in order to produce a memorable and scientifically high quality congress. The theme of the World Congress is Infant Mental Health in a rapidly changing world: Conflict, adversity and resilience.

The Call for Papers will be soon sent to you and the Congress website opened. Those of you planning to submit a presentation will be happy to know that the online submission of abstracts will start April 1st 2015 and the deadline for Abstract Submissions will be September 15th 2015.

We here at the WAIMH Central Office wish you all a Happy and Successful year 2015, and hope to see as many of you as possible in the Prague Congress!

Membership

Please renew the WAIMH membership for the year 2015. Go online to the website of the association: www.waimh.org.

There are two separate categories: the student (45 USD) and professional (75 USD) memberships. As a WAIMH member, you have the privilege of ordering the Infant Mental Health Journal at a special rate.

The rates differ according to your country: USA 50 USD, Canada 52.50 USD (including tax) and International orders 62.50 USD. All journal subscriptions are also including access to the online IMHJ at the Wiley. A new popular form of getting access to the journal is the online only option, which is available for members worldwide at the fee of 40 USD.

Please, contact the Central Office of the association, if you need guidelines or support for the membership renewal (office@waimh.org).

Figure. WAIMH members 31.12.2014 and WAIMH affiliates and merging affiliates.

15th World Congress of the World Association for Infant Mental Health

May 29 – June 2, 2016
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Czech Republic

Registration Contact
GUARANT International spol. s r.o.
Na Pankraci 17, 140 21 Prague 4
Czech Republic
Tel.: +420 284 001 444
Fax: +420 284 001 448
E-mail: waimh2016@guarant.cz

www.waimh.org
www.waimh2016.org

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

The Congress is organized by WAIMH in cooperation with the Israeli Infant Mental Health Affiliate and Palestinian Infant Mental Health specialists.