

Perspectives in Infant Mental Health

Professional Publication of the World Association for Infant Mental Health

An Experience of Reflective Practice - Finding a Reflective Space

By Siobhán Bruen, Social Worker, Ireland

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I have been working as a Social Worker with children and their families for the last eighteen years. In 2006 I attended an Infant Mental Health Master Class facilitated by Deborah Weatherston of the Michigan Association of Infant Mental Health and Catherine Maguire and Rochelle Matacz of the Cork Health Health Services. I, along with other members of my team, have been involved in an Infant Mental Health Network Group since then. A central feature of the infant mental health model is reflective supervision. "Most IMH specialists learn to use the supervisory relationship to reflect on the complex emotional realities of overburdened families and infants at risk. The IMH specialist may be affected deeply by individual infants and families ..she needs to have time to discuss what is seen and heard" (Weatherston, 2000, p.9).

In 2009 I completed a Postgraduate Diploma in Advanced Fieldwork Practice and Supervision in University College Cork, Ireland. As a participant of this course I was expected to keep a learning journal, and to engage in a process of reflective learning. I was also a member of a peer group which met regularly to provide members with opportunities to engage in reflection. This reflective model of learning is set out in an article by Demspey et al, 2001. They make reference to the use of Kolb's learning cycle, and Steve Seidel's framework «which involves the learner in looking backward, looking inward, looking outward and looking forward." The importance of reflective practice and supervision has been a recurring theme for me in my studies and in my work experiences and also in recent reports regarding social work with children and their families. Eileen Munroe talks about expertise in social work and how this is developed. She says: "Experience on its own is not enough. It needs to be allied to reflection – time and attention given to

mulling over the experience and learning from it". (Munroe, p.87). "The emotional dimension of working with children and families plays a significant part in how social workers reason and react. If it is not explicitly discussed and addressed then its impact can be harmful. It can lead to distortions in social workers' reasoning because of the unconscious influence it has on where attention is focused and how information is interpreted." (p.91)

In the current climate of limited resources, reduced access to training, and increasing pressure on managers we have to be creative in finding the space for reflection. As a social worker I receive regular supervision. However due to the demands of the service this mostly focuses on case management, with little opportunity for reflective space. This challenged me to look at my experiences of supervision and find a space for critical reflection, for on-going learning, and growth. This then led me to have discussions within my team about how we might look to providing each other with support and, as a result, improve the quality of service to the children and families we work with. It has been creative and collaborative effort.

What follows is an example of how members and I from my team drew on our own resources to create a reflective space. As a team we acknowledged the inherent complexity and uncertainty in the work we do and the emotional impact of it. We identified a need for a reflective space to help us gain a better understanding of our own experiences in practice, further developing our conscious awareness of the impact of our work, including the impact we have on service users. With support from University College Cork (UCC), members of the Department of Applied Social Studies Carmel Halton, Marion Murphy and Applied Psychology, Maria Dempsey we began negotiating



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around setting up Reflective Learning Groups in our team. They had previous involvement in introducing a model of peer reflective practice in a social work agency. (Dempsey et al, 2008). In May 2010 we had two such groups up and running. We meet monthly for 1 ½ hours. My experience of being involved in this group appears below:

I keep a learning journal. I write in this regularly about my practice experiences and issues that arise for me. I use this to reflect on the work I do, to bring to conscious awareness the feelings I have and to better understand the role they play in my relationships with service users. I use it to identify questions I have and to consider what I could do differently. The journal is then one of the means used of engaging in the reflective process in the group – having the opportunity to read aloud, to be listened to, and to be supported in exploring feelings, thoughts, actions through thoughtful and at times challenging questions from my peers. The group provides space for further reflection, for planning further action, for making connections between theory and practice.

So what works for me:

- The focus is on "I" – owning and taking responsibility for my thoughts, feelings and actions.
- Having the space to explore experiences, to bring into my conscious awareness the feelings and emotions I experience and consider the impact of these on my work and on service users
- The journal and the group provide me with support and structure to connect with the emotional impact of the work, and the impact of my relationships with service users. This helps me to better understand from what basis I am working and to keep the best interests of children and their families at the centre of my practice.
- As a result of the group I can make better use of formal supervision with my manager. I am clearer about the issues I need to bring to supervision.

The challenges:

- The process is not always easy – bringing together a group of people, negotiating ground rules, developing trust, being supportive rather than judgmental, giving and receiving authentic feedback.
- Continuing to find time within an increasingly pressured work environment to use the journal, and

attend the meetings

Being part of such a group has been important to sustaining me in my work. It has enriched my engagement with service users and I believe has led to better decision making in the best interest of children.

The support we received initially from UCC was important in helping us establish and sustain the groups and to overcome the challenges in the first year. Now we manage the groups ourselves. We don't always come up with the answers but generally are clearer about what the questions are. I believe this is a creative development in our team which has enhanced our practice and is a model which could be replicated to provide reflective space for practitioners working in social work teams.

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From the Editors: The World in WAIMH: A Reflective Space on Context, Culture and Community

By Deborah Weatherston, Hiram E. Fitzgerald, Michigan, USA and Maree Foley, New Zealand,

Editors

The editors of Perspectives, editorial board members, WAIMH Board members and members were deeply affected by what they heard and experienced at the WAIMH 2012 Congress in Cape Town. In response, the editors of Perspective are delighted to announce the birth of The World in WAIMH, an occasional column intended to open up a space for reflection and dialogue on the roles of context, culture, and community in infant mental health. Our shared hope is that this will offer a place for questioning, challenge, dialogue and interdisciplinary discussion.

For decades now, the field of infant mental health has conceptualized human development as transacted within dynamic systems made up not only of the infant's family, but also of the broader social, economic, political and physical spheres in which they are situated. Bronfenbrenner's ecological model and Sameroff's transactional model are often invoked, but their implications for infant mental health practices still hold much untapped potential, leaving many questions for us to explore:

- What do infant mental health professionals need to know about the institutions and environments and other constituents of the systems in which infants and families develop?
- What interactions can or should infant mental health professionals – and their professional organizations- engage in with the members of the dynamic systems beyond the family in which infants develop?
- Would such interactions dilute the work or overwhelm mental health professionals? Can their goals be achieved for all infants any other way?

In our globalized world, every infant and family is affected by forces far beyond their reach, forces that may strengthen, hinder, or undo the work of infant mental health professionals. To be a truly global organization, WAIMH will increasingly need to understand and develop strategies to address these forces. In addition, to foster healthy early development around the world, WAIMH will need to extend its reach, and to learn from contexts, cultures and communities that are not or only minimally represented in its current membership. Many questions come to mind:

- What processes can contribute to a more inclusive and expansive knowledge base?
- What kinds of partnerships – with members of cultures not yet represented within WAIMH, with other

organizations, with other disciplines such as cultural anthropology or community psychology – are needed to truly put the world in WAIMH?

Roughly 97% of academic research on developmental psychology has focused on less than 1% of the world's population and many of its findings have mistakenly been assumed to be universally applicable, leading us to ask:

- What do we know, and how can we learn, about infant mental health around the world?
- How do local contexts, cultures and communities understand, affect and optimize infants' development? What are the implications of contextual specificities – for example, how 'family' is defined - for infant mental health intervention design?

In the United States, a shocking 20% of children are currently living in poverty. Despite expanded healthcare coverage, most of those who need infant mental health services do not have access to them. Yet in many developing countries, efforts to improve infants' survival rates still often take precedence over efforts to ensure their healthy development, inviting us to think more deeply:

- What is the role for infant mental health services in countries like these?
- What would it take for infant survival and development to be integrated, and what would this look like in different contexts, cultures and communities?
- How can infant mental health services be scaled proportionally to the needs?
- What role can mental health prevention and promotion play in these settings?
- What role should infant mental health and WAIMH play in scaling prevention and promotion strategies?

The Editors propose to create a space to explore issues relevant to the health and mental health of infants, very young children and their families. Joshua Sparrow, Brazelton Touchpoints Center, Director of Planning, Strategy and Program Development Boston, MA, has enthusiastically agreed to coordinate this column. We are calling for concept papers, research articles, adaptations of articles, and literature reviews that address questions such as these and that pose other pressing ones. We look forward to your reflections and hope that vigorous dialogue in this reflective space will ensue.

President's Page

By Miri Keren, Israel

President of WAIMH

As promised in my previous Presidential Address, I wish to inform all our members about what the Board has done since our last conference in Cape Town, but not before I share with you the emotion I felt while reading Karlen's funny and beautiful description of Dan Stern's way of celebrating life and ideas. Here, in Israel, Dan's ideas have been so deeply infused into our work that we felt compelled to organize a memorial conference day next month with his wife, Nadia.

Very much in light of what is described in this issue of Perspectives, under the title of «Diversity-Informed Infant Mental Health Tenets: Together in the Struggle for Social Justice,» the present Board, together with our past presidents, Tuula Tamminen and Bob Emde, and our past Executive Director, Hiram Fitzgerald, we have been in the process of writing a first draft of a Declaration of Infant's Rights. You will soon receive this draft to reflect on and send any comment/suggestion you may have to the WAIMH Central Office. We invite your feedback before we finalize the proposal and present it at our next conference in Edinburgh, 15-18 June, 2014.

A second task in which we are very much involved is the revision of the DC 0-3R, as a joint effort of the WAIMH and ZERO TO THREE organizations. Again, you will receive in the near future a survey about how much you use the DC 0-3R in your current practice, clinical as well as research. The revision will use the results of the survey, as well as updated literature reviews about each diagnosis. The whole process is supposed to take three years, starting from May 2013, and is sponsored by the ZERO TO THREE organization.

A major change has been initiated regarding the way the WAIMH Board and the Executive Committee use the time in-between the conferences. Indeed, the new electronic facilities enable us to have frequent, cheap, video-call meetings at which we can discuss in real time any topic we wish. In the past, due to logistical constraints, we had one Executive Committee meeting per year, with many expenses, and one WAIMH Board meeting prior to each world conference. This new way, we can accomplish much more especially if we are disciplined and stick to the rules of turn-taking and time limits! Still, we are only at the beginning of this new way of meeting. Our last video call was indeed dedicated to the topic of developing our WAIMH Social Media so that our outreach to one another and to new members around the world can be more immediate. We want to have much

more contact between the Affiliates and the Board in the coming years, ongoing instead of just meeting every two years in the course of the conference.

Because it is time to elect new Board members, the Board itself will also be changing. As you know, Campbell Paul and Deborah Weatherston have served for one 4-year term. Campbell has agreed to run for a second term..

Deborah will continue as Editor of WAIMH Perspectives (formerly, The Signal) but will not run for a second term. You have been asked to vote for two new Board positions. We were very pleased...and proud...to receive five excellent candidates from all over the world.

Last, but not least, we are about to launch the Call for Papers for our next World Congress, that is to be held in Edinburgh, 15-18 June 2014....So get ready!

We really wish to fill you in between our world conferences, through on-going conversations using new technology, through dialogue in Perspectives, sharing interesting clinical experiences with one another, and especially letting us know about the major progress and problems you encounter in the field of IMH in your own country and society.

Very warmly to all of you.

Guided by an inner link between Fukushima and Hiroshima: In the aftermath of the Great North-Eastern Earthquake in Japan

By Natsuko Tokita, Department of Pediatrics, Keio University

The Great North Eastern Earthquake with tsunami in Japan on March 11, 2011 triggered the blast of Fukushima No1 Nuclear power plant 3 days later. A week later, I phoned my friend and pediatric colleague Dr. Shintaro Kikuchi and his father Dr. Tatsuo Kikuchi, a senior pediatrician who is the president of the Medical Society of the City of Koriyama, Fukushima. Together they run a pediatric clinic. Shintaro sounded extremely concerned: "Our local children are in danger of the kind we have never experienced."

On 21st March, 10 days after the disasters, I visited Koriyama in Fukushima with Dr. Hisako Watanabe, a child psychiatrist at Keio University who was the chair of the 2008 WAIMH congress in Yokohama. We barely saw people walking in the streets. Those who did wore masks and hats and the whole town was in a heavy mood. "We must protect the children of Fukushima. No single PTSD in children!"; the Kikuchi doctors' determination and urgency sparked us to act promptly. On that day we laid the foundation of the "Koriyama Post-Disaster Child Psychological Care Project" in collaboration with the local government and medical society, which resulted in

an open symposium of child workers of Koriyama on 9th April, 2011.

The project harbored the concept of "Integrity, Structure and Continuity", and focused on providing a secure base for children, with an emphasis on the prevention and early detection of PTSD in a natural daily-life context. For example, we facilitated volunteers experienced in reading picture books to children to visit evacuation areas and nurseries. We chatted with and befriended parents of young children who appeared worried. Also we empowered parents to prevent PTSD in their child by creating an accessible leaflet entitled "Why not hug your child". Its

copy was distributed to all 50,000 families with young children in Koriyama. Health visitors provided intensive care to all pregnant mothers in the community which prevented abortion from fear.

Our endeavor caught the eyes of a good old friend of Dr. Tatsuo Kikuchi, who is a chairman of a successful local supermarket company. With his generous offer of land and funds combined with an active dedication of a leading toy company, an all season indoor playground for children up till 12 years of age was constructed. Opened on the 23rd of December, 2011, "PEP KIDS KORIYAMA", the largest and most advanced indoor playground for children in North-Eastern Japan was opened as a Christmas present from the local Santa Claus. Children were able to leave their homes and go to a safe place to play in a lively way to the relief and joy of parents. Now 15 months later, 400 thousand visitors have already played at the PEP KIDS, which revealed the invigorating power of children at play for the revival of the whole community.

The Kikuchis strove restlessly for 2 years since the disasters. Their achievements have come to be highly approved. This year Dr. Shintaro Kikuchi has been newly appointed as a member of the Ministry of Restoration Promotion of the Government of Japan. There are numerous emergent difficult problems ahead: obesity in children of all ages caused by the lack of outdoor play and activities, the psychological impact of the changes in family structures, the ill-effects on local agricultural and marine industry of rumors of radiation contamination on products of Fukushima. Dr. Kikuchi now has a new role of becoming the voice of the people of Fukushima to the government.

The Project anticipates the much awaited construction of an all-season indoor playground for older children and adolescents as huge as the Tokyo Baseball Dome..

My commitment in the Project sparked me to reflect on the link between my paternal and maternal roots: the former is Fukushima, where the nuclear power plant disaster occurred and the latter is Hiroshima where the atomic bomb was dropped. My father comes from a medical family in Fukushima. He started his medical practice in Tokyo but when one of his medical relatives fell ill, he had to return to his hometown to replace him there, leaving his family in Tokyo. In the immediate aftermath of the Fukushima disaster, when almost all doctors and nurses fled, he made up his mind "to stay to save my patients" and helped overcome the crisis.

On 6th August, 1945, when an atomic bomb was dropped on Hiroshima, the first overseas report of the disastrous scene was sent by my maternal grandfather, Leslie Nakashima, who was a second generation Hawaiian Japanese. He was a newspaper reporter and the eldest of 11 siblings. At age 23, he chose to be a USA citizen, out of his dual nationality of Japanese and American. He came to Japan at the age of 32 and worked for a newspaper company in Tokyo. He got married to a Japanese lady at the age of 36. In the following year a baby girl was born and she was my mother.

The war started when he was 39. He was regarded as an enemy alien, which led to police surveillance and he lost his job. He converted to Japanese nationality to protect his family. He was in Tokyo at the time of the Hiroshima atomic bomb. Concerned about his mother who lived in Hiroshima, he ventured alone into the city 16 days later. "I was wordless at the site of the ruins. The only thing left was a concrete platform of the station. The metropolis of a population of 300,000 was gone." His article was written in weariness from the radiation exposure and was telegraphed to the USA on 27th August. The article appeared in a newspaper in Honolulu on 30th August and in the New York Times on 31st August, 1945.

His wish to regain his USA citizenship was rejected by the Japanese government and he died in Japan as Japanese. My grandfather never confided his wartime experience to any of his grandchildren, while he was always warm with a cheerful smile. Now I cannot but wonder how he must have felt sending his article to his homeland, the USA, as a 'Japanese' reporter who in fact maintained his identity as a local Hawaiian boy. In hindsight it was my feelings of respect and redemption towards my father working in Fukushima deprived of his family, and my grandfather sending his historical article to the USA that must have led me to Fukushima in the immediate aftermath of the disaster.

In Japan today, children are adversely affected both psychologically and physically by ever increasing artificial elements of our internet technology society. In Fukushima, the citizens were called to rise to the occasion and be responsible for ensuring the survival of their children in the community with firm determination to remain and live there. The slogan by Dr. Kikuchi, "A true restoration of children in Japan comes from Fukushima" rings true after 2 years. We would like to have you remember Fukushima always. Your support from all over the world will keep us going.

14th WAIMH WORLD CONGRESS

14th - 18th June 2014
Edinburgh International Convention Centre

Babies: Their Contributions - Our Responsibilities



Key Dates:

Abstract Submission: 15th September 2013
Notification of Outcome to Authors: 16th December 2013
Early Registration: 17th March 2013

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Reminiscences of Daniel Stern: A Creative Intellectual

By Karlen Lyons-Ruth, Member of the
Change Process Study Group

Boston, Massachusetts

Dan was a creative intellectual force in psychiatry, and other contributors to this memorial issue *Others* (Perspectives in Infant Mental Health, Vol. 21, 1, Winter, 2013) have addressed have already addressed his seminal contributions to psychoanalysis and developmental psychology. So, instead of talking about his accomplishments, I'd like to reminisce about how much fun he was to be with.

I knew Dan as part of a creative experiment in thinking that pulled a diverse group of strong-willed psychoanalysts and developmental psychologists into close proximity for the past 18 years to think about how change occurs in psychotherapy. Initially, I had my doubts about the whole endeavor. This was a grandiose and impossible topic, at best. At worst, it could have been a breeding ground for intense intellectual conflict, painful disagreements, and mounting frustration.

Instead, it proved to be the adventure of a lifetime. And it was a great adventure largely because of Dan's ability to disarm, diffuse, distract, and, generally, charm us all away from those moments of fierce intellectual standoff that threatened to become personal. I still don't know how he did it.

Dan's spirit of whimsy and play were his special gift. He could turn on a dime from a penetrating summary of the last three hours of discussion to a moment of fantasy, or a burst into song, or a quick joke. Just when you thought you were in terminal conflict with him, he was giving you a bear hug and dragging you up from your chair into a soft-shoe routine complete with canes and hats. What's not to like about this guy?

Dan knew how fragile an idea could be, and he was fierce in defense of fragile ideas so they had room to grow and develop. I think it was his completely forgiving acceptance of other people that allowed



From left Christine Schechter, Daniel Schechter, Karlen Lyons-Ruth, Nadia Stern, Daniel Stern, Sandra Rusconi Serpa and Francois Ansermet in Geneva (April 2010). Photo by Bill Ruth.

him to be so intellectually fierce. He could turn any moment of building tension and locked intellectual horns into a warm embrace, and I know that many others had that experience of Dan. He thrived on confrontation and resolution, gladiatorial combat followed by a drink at the bar, thundering his point and then letting it go and giving over to someone else's persuasive argument. So it became a lot of fun to fight with him, when you knew at the end of the day you could look forward to a poker game, or cognac and cigars, or some wine and chocolate.

I remember going to a restaurant in Naples in the late afternoon after a long overnight flight, and somehow by the end of the meal Dan had all of us singing arias with the waiters. I remember him, in his best Paul Newman style, upping the betting in a vicious poker game on Virgin Gorda. I remember he and Jeremy Nahum doing old camp skits for Lou Sander's 80th birthday party. I remember Dan in Italy grabbing a surprised street cleaners' broom and sweeping the streets of Rome for an impromptu photo op. And of course, every joke I know came from Dan.

My favorite pictures of Dan, which I always show when teaching Dan's work to child psychiatrists, were pictures taken one evening in Nantucket after a particularly

intense day of struggling with a dispute in the group. Some music was playing on the radio after dinner and Dan jumped up and started dancing with Alice, and then with Adrian, and finally with Lou Sander, who was then in his 80's but still very light on his feet. That picture of Dan dancing with Lou is one I'll always treasure.

One of Dan's greatest jokes involves a cloistered monk late in the 15th century. This monk was in charge of overseeing the rules of monastery life, and one day he decided to go back into the depths of the dust-covered stacks of illuminated manuscripts to find out what the sacred text had said in the original version, before centuries of laborious copying had occurred. The monk was gone for a long time and his assistant became worried and went down into the stacks to check on him. He found the old monk bent over the original text, sobbing and sobbing. He rushed over and said, "Father, what's wrong? What's wrong?" The old monk slowly raised his head and said, "In the original, it says, Celebrate!"

Dan had a special gift for celebrating life, and I celebrate his life with all of you through this special memorial tribute.

Diversity-Informed Infant Mental Health Tenets: Together in the Struggle for Social Justice



National Center for Infants,
Toddlers, and Families

By Maria Seymour St. John

University of California, San Francisco

Kandace Thomas

Irving Harris Foundation

Chicago, Illinois

Carmen Rosa Noroña

Division of Developmental and Behavioral
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ZERO TO THREE Corner

To create a just and equitable society for the infants and toddlers with whom its members work, the infant mental health field must intentionally address some of the racial, ethnic, socioeconomic, and other inequities embedded in society. The Diversity-Informed Infant Mental Health Tenets, presented and discussed here, are guiding principles outlining standards of practice in the field and pointing the way to a just society via engaged professional practice. Copyright Irving Harris Foundation. For more information about the Diversity-Informed Infant Mental Health Tenets please visit www.imhdivtenets.org, email contact@imhdivtenets.org or call +1-312-621-3814.

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Irving Harris Foundation

Over the past 30 years, the field of infant mental health has evolved exponentially. Within this multidisciplinary field, practitioners of all kinds — clinicians, researchers, practitioners, and policy makers — all work to ensure the emotional, physical, social, and cognitive well-being of children from the prenatal period through 3 years. The field's work has been elevated partly because of what the science reveals about brain development and early experiences, and other critically important research that demonstrates how a young child's experience can shape long-term outcomes. In the past few years, the field has made great policy gains such as the increased federal funding to support early learning programs, federal funding for home visiting, and other policy efforts that support young children's healthy development.

Significant to this work has been the training, capacity building, and development of innovative programs led by members of the Harris Professional Development Network (PDN). Over the past 20 years, the PDN has played a critical leadership role in changing the landscape of services for infants and small children by promoting infant mental health and child development and by integrating core principles of infant mental health into systems and services that work with the most vulnerable children in the United States and Israel. These programs have also created models to work with children in war zones and children facing natural disasters. The PDN has been instrumental in professionalizing infant mental health providers by creating certificate

Diversity-Informed Infant Mental Health Tenets

1. **Self-Awareness Leads to Better Services for Families:** Professionals in the field of infant mental health must reflect on their own culture, personal values, and beliefs, and on the impact racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression have had on their lives in order to provide diversity-informed, culturally attuned services on behalf of infants, toddlers, and their families.

Stance Toward Infants and Families

2. **Champion Children's Rights Globally:** Infants are citizens of the world. It is the responsibility of the global community to support parents, families, and local communities in welcoming, protecting, and nurturing them.
3. **Work to Acknowledge Privilege and Combat Discrimination:** Discriminatory policies and practices that harm adults harm the infants in their care. Privilege constitutes injustice. Diversity-informed infant mental health professionals work to acknowledge privilege and to combat racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression within themselves, their practices, and their fields.
4. **Recognize and Respect Nondominant Bodies of Knowledge:** Diversity-informed infant mental health practice recognizes nondominant ways of knowing, bodies of knowledge, sources of strength, and routes to healing within diverse families and communities.
5. **Honor Diverse Family Structures:** Families define who they are comprised of and how they are structured; no particular family constellation or organization is inherently optimal compared to any other. Diversity-informed infant mental health practice recognizes and strives to counter the historical bias toward idealizing (and conversely blaming) biological mothers as primary caregivers while overlooking the critical child-rearing contributions of other parents and caregivers including fathers, second mothers, foster parents, kin and felt family, early care and educational providers, and others.

Practice/Research Field Principles

6. **Understand That Language Can Be Used to Hurt or Heal:** Diversity-informed infant mental health practice recognizes the power of language to divide or connect, denigrate or celebrate, hurt or heal. Practitioners strive to use language (including "body language," imagery, and other modes of nonverbal communication) in ways that most inclusively support infants and toddlers and their families, caregivers, and communities.
7. **Support Families in Their Preferred Language:** Families are best supported in facilitating infants' development and mental health when services are available in their native languages.
8. **Allocate Resources to Systems Change:** Diversity and inclusion must be proactively considered in undertaking any piece of infant mental health work. Such consideration requires the allocation of resources such as time and money for this purpose and is best ensured when opportunities for reflection with colleagues and mentors as well as on-going training and consultation are embedded in agencies, institutions, and systems of care.
9. **Make Space and Open Pathways for Diverse Professionals:** Infant mental health workforces will be most dynamic and effective when culturally diverse individuals have access to a wide range of roles, disciplines, and modes of practice and influence.

Broader Advocacy

10. **Advance Policy That Supports All Families:** Diversity-informed infant mental health practitioners, regardless of professional affiliation, seek to understand the impact of social policies and programs on diverse infants and toddlers and to advance a just policy agenda for and with families.

programs, disseminating evidence-based treatment models such as Child-Parent Psychotherapy, and replicating innovative programs such as Minding the Baby and Fussy Baby.

Despite major successes deepening the field, there continue to be vast unmet needs across the socioeconomic spectrum of young children and their families, with particularly unacceptable gaps in access and quality of mental health and early childhood learning services for poor children, many of whom are African American, Latino, or Native American or represent other non-dominant racial and ethnic communities. In many cases, professionals in the infant mental health

field are disproportionately Caucasian, while many of the most vulnerable young children are children of color. In order to create a just and equitable society for the infants and toddlers with whom its members work, the field must intentionally address some of the racial, ethnic, socioeconomic, and other inequities embedded within society.

To begin to address these inequities, the PDN, as a group, has made one of its primary goals to deepen the field's commitment to diversity-informed, culturally attuned, inclusive, and equitable practice. To that end, members of the PDN studied some of the incisive and influential statements of core values of infant mental health and many ground-

breaking innovations addressing diversity and inclusion that were underway across the disciplines and around the globe. This research revealed that diversity issues tended to be held as an area of specialized knowledge (e.g., infant care practices of a particular cultural group) or as a special skill set (e.g., the idea of "cultural competence"). What was missing was a shared vision of the role played by human diversity in those very principles and practices universally embraced within the field. Certain core principles of infant mental health, such as the importance of early relationships, are difficult to uphold evenly within a society where certain groups and relationships are recognized and revered, while others are discounted

or denigrated. It became clear that infant mental health is a matter of social justice. Wide recognition exists regarding the urgent necessity of protecting and promoting the health and well-being of infants and small children. Yet, there are no guidelines for equitably working toward this end given the cultural and institutional barriers based on class, race, and other inequities with which professionals all live and work. Thus, the PDN created the Diversity-Informed Infant Mental Health Tenets (see box) in an effort to offer such guidelines. The Tenets are a working document putting forth a vision of a society and a field in which all infants and toddlers – regardless of racial and ethnic identity, family structure, and ability – will be recognized, respected, and well-served. Most of the Tenets expand on familiar principles of infant mental health. The Tenets attempt to expand the core principles through a diversity, inclusion, and fairness lens. The Tenets are divided into three sections: (a) stance toward infants and families; (b) practice/research field principles; and (c) broader advocacy. Each Tenet is discussed in terms of not only what makes it important, but also what makes it difficult to uphold. It is hoped that this working document serves to bring together diverse practitioners committed to eradicating barriers to the healthy development of all infants, families, and communities. We submit that in this sense, professional development in the field of infant mental health means striving for social justice.

Moving Toward Diversity-Informed Practice

The field of infant mental health has come a long way in a short time. Reflecting on the origins of the field, Selma Fraiberg (Fraiberg, Shapiro, & Cherniss 1980) once recalled the public outrage with which the creation of the first infant mental health program in the nation was met. “When a two-line announcement appeared in our local newspaper that a professor in the department of psychiatry had received a grant from the National Institute of Mental Health for an infant program,” Fraiberg wrote, “an irate taxpayer promptly wrote a letter to the editor demanding to know why the taxpayers should be asked to support a crazy woman professor who wanted to put babies on a couch and psychoanalyze them” (p. 49). Discomfort with the phrase “infant mental health” persists today. This discomfort can include the potential implications of the idea of mental illness, as well as concern that the term is too limited in some ways (e.g., it narrows the developmental age range, highlights only some domain(s)

of developmental concern, or implies the need for the services of particular professional disciplines to the exclusion of others).

Those who promote the term infant mental health, however, embrace a holistic view of the infant in the context of family and community and intend the phrase to describe the conditions of infants’ healthy development and general well-being. To that end, ZERO TO THREE (2001) put forward the following definition of infant mental health, suggesting that this phrase describes

the young child’s capacity to experience, express and regulate emotions, form close and secure relationships, and explore the environment and learn. All of these capacities will be best accomplished within the context of the caregiving environment that includes family, community, and cultural expectations for young children. Developing these capacities is synonymous with healthy social and emotional development.

Professionals in the field have developed key infant mental health concepts or principles to guide multiple avenues of effort including policy, research, training, and practice. Examples include the work of the Michigan Association for Infant Mental Health (Weatherston, 2002) to develop practice standards and an interdisciplinary workforce plan, the MI-AIMH Endorsement for Culturally Sensitive, Relation-Focused Practice Promoting Infant Mental Health; (California Center for Infant/Family and Early Childhood Mental Health; Heffron, 2011) to provide training guidelines and a professional endorsement system; and the California Interagency Coordinating Council on Early Intervention (2010) to develop practice standards for early intervention personnel. In reviewing knowledge bases from multiple disciplines, Zeanah and Zeanah (2009) identified points of consensus that also serve the function of guiding principles.

There are consistent themes among these documents. Early experiences, development, and relationships are of special importance throughout the life span. When constitutional or contextual vulnerabilities, or both, are present, children and families benefit from services and supports that are collaborative with them and informed by multidisciplinary perspectives. The field has considerable

science knowledge and practice experience to support translating these principles into action.

In the early decades of the field—the “color blind” years—writing tended to focus on an imagined universal infant without regard to the sociocultural and historical-political context as a shaping force. In recent years, the importance of culture in influencing infant and family experience has been widely recognized and many authors note the importance of considering culture in planning and implementing interventions in support of infants, toddlers, and their families. The groundbreaking report of the National Research Council and Institute of Medicine (2000) on the science of early childhood development asserted that “culture influences every aspect of human development and is reflected in child-rearing beliefs and practices designed to promote healthy adaptation (p. 25);” but concluded that while this basic concept is compelling, “the database is thin and the imperative for extensive research is clear.” With respect to research, the Council noted several challenges to studying the contributions of culture to parenting and child development, including lack of diversity in the children and families on whom research has been conducted as well as the need for far greater integration across the relevant disciplines (e.g., anthropology, ethnography, and sociology as well as the more typically represented early childhood fields) in research terminology, design, and practice. With respect to service systems and delivery, the Council articulated several characteristics regarding cultural competence. These included identifying underserved groups and eliminating culture-based barriers to service provision; monitoring the cultural appropriateness of assessment, research, and intervention procedures for the target families; and facilitating policy planning, staff training, and community participation in order to ensure the development, delivery and maintenance of culturally competent services.

The notion of cultural competence has been transformative within the field of infant mental health and across the disciplines that comprise it, bringing urgent attention to the necessity of building awareness of the influence of culture on practitioners, families, institutions, and systems (Maschinot, 2008). Yet some have noted that important components of human diversity that must also be considered and addressed in infant mental health work fall outside of the category of culture. For example, Ghosh Ippen (in press) has suggested that “culture,

while of critical importance, is [just] one factor among many to consider” and points to age, gender, immigration history, culture of origin, acculturation, social class, and trauma history as examples of salient aspects of experience that may not be touched by a cultural competence framework. Furthermore, a focus on culture often implies a focus on the culture of the recipients of infant mental health services, rather than on the influence of intersecting forces of oppression on provider–family relationships, on shaping research designs, or on systems of care more broadly. Ghosh Ippen (2009; Ghosh Ippen & Lewis, 2011) propose an alternate framework—diversity-informed practice—in order to account for these broader issues. She described it this way: “Diversity-informed practice is dynamic, focusing not just on values, beliefs or experiences of a group or individual but on interactions among people with different views. It also involves an understanding of how interactions are shaped by the larger sociopolitical and historical context” (in press). In the present document, the term diversity-informed practice is adopted in order to tap these many strata of human experience and strive for the highest possible standard of inclusivity in all spheres of practice: teaching and training, research and writing, policy and advocacy, as well as direct service.

Considering the Diversity-Informed Infant Mental Health Tenets

The Diversity-Informed Infant Mental Health Tenets have been devised to support all those in the field in working toward social justice and inclusivity. The discussion that follows describes each Tenet in the context of the serious impediments a professional faces in striving to uphold it.

1. **Self-Awareness Leads to Better Services for Families:** Professionals in the field of infant mental health must reflect on their own culture, personal values and beliefs, and the impact racism, classism, sexism, able-ism, homophobia, xenophobia and other systems of oppression have had on their lives in order to provide diversity-informed, culturally attuned services on behalf of infants, toddlers, and their families.

The first and arguably the most important step to providing diversity-informed services is an examination and understanding of one’s own background, experiences, and identities. This awareness

of one’s personal assumptions, values, and biases ultimately allows the practitioner to differentiate between the families served and his assumptions. This awareness, including awareness about personal privilege and societal privilege generally awarded to heterosexual, middle-class majority groups, informs the practitioner’s relationship with colleagues and clients, as well as the work the practitioner engages in on behalf of clients. Awareness and consciousness of one’s cultural background, beliefs, and biases develop best in tandem with a dedicated effort at understanding others’ cultural beliefs and heritage. In this process, the infant mental health practitioner acknowledges the ways in which the “isms” listed here lead not simply to instances of discrimination between individuals but also to institutionalized forms of injustice. Note that this Tenet is closely linked with Tenet #8, which recognizes the critical importance of dedicating agency resources to supporting this important aspect of individual professional development.

Stance Toward Infants and Families

2. **Champion Children’s Rights Globally:** Infants are citizens of the world. It is the responsibility of the global community to support parents, families, and local communities in welcoming, protecting, and nurturing them.

If one embraces the core values and guiding principles of infant mental health discussed in the section above, one is hard pressed to apply them to only certain groups of human infants. One would not say, for example, “relationships matter - for American babies.” Rather, it must be recognized that all infants offer and require much, and it is the responsibility of the world community to ensure that caregivers have access to adequate resources that are compatible with family and local cultural values. Diversity-informed infant mental health practice entails cultivating an awareness of the plight of infants locally and around the globe, and fostering their well-being in keeping with one’s unique capacities and resources.

The United Nations Convention on the Rights of the Child (UNICEF, 2012) created a human rights treaty delineating the civil, political, economic, social, health, and cultural rights of children. It came into force in 1990 and has yet to be ratified by the United States despite its being embraced almost unilaterally by other members of the United Nations. Many of its articles reflect the notion of infants as citizens of the world, including the simply

stated Article 6: “Children have the right to live. Governments should ensure that children survive and develop healthily.” Given the large numbers of immigrant cultures in the United States, Article 10 has special significance here. It states that “Families whose members live in different countries should be allowed to move between those countries so that parents and children can stay in contact, or get back together as a family.” Diversity-informed infant mental health practice and policy recognizes that love knows no borders and that infants’ best interests are served when those who love them are able to care for and protect them.

3. **Work to Acknowledge Privilege and Combat Discrimination:** Discriminatory policies and practices that harm adults harm the infants in their care. Privilege constitutes injustice. Diversity-informed infant mental health professionals work to acknowledge privilege and to combat racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression within themselves, their practices, and their fields.

Infant mental health is a social justice issue because discriminatory policies and practices that harm adults harm the infants in their care. Such practices may limit adults’ capacities to protect and nurture the infants in their care in overt or covert ways. For example, prohibitions against interracial marriage in the past, or today against same-sex marriage or marriage among adults with disabilities impedes parents’ ability to claim, care for, protect, and provide for their children in material ways and also inflicts psychological wounds for parents that can negatively impact parenting relationships. In addition to overtly discriminatory policies and practices, marginalized groups are routinely subjected to covert forms of oppression. With respect to race, insidious forms of racism include structural racism (as reflected, for example, in the gross overrepresentation of children of color in the child welfare system or the race-based achievement gap that is ubiquitous in education systems across the nation); white privilege; internalized racism; and racial microaggressions (Sue, 2010). Diversity-informed infant mental health practice entails identifying and working to eradicate both overt and covert forms of discrimination within one’s personal and professional spheres.

As systems and institutions often reproduce aspects of the forces of oppression that operate in society at large, problematic patterns and divisions of labor can easily be reproduced even

within well-meaning infant mental health agencies. For example, higher-status positions may be held by dominant group representatives who may be less sensitive to or invested in combating various forms of oppression, leaving such battles to be fought by professionals representing non-dominant groups. Diversity-informed infant mental health agencies and systems of care must work to ensure that professionals representing minority status groups do not shoulder an undue burden (e.g., combating racism or other systems of oppression in the workplace, serving especially vulnerable families, striving for inclusivity). Such efforts are shared among all infant mental health professionals and supported by agency and community policies.

4. Recognize and Respect Nondominant Bodies of Knowledge: Diversity-informed infant mental health practice recognizes nondominant ways of knowing, bodies of knowledge, sources of strength, and routes to healing within diverse families and communities.

Professionalization processes involve knowledge-production, behavior-regulation, and standard-setting, and foster identification with and investment in each of these. Each professional is a steward of the funds of knowledge and approaches to practice that the professional inherits, but each also has a responsibility to critique, adapt, expand upon, and see beyond inherited ways of understanding and doing things. Rather than seeing themselves as the sole holders of knowledge and sources of healing, diversity-informed infant mental health practitioners listen carefully to the infants and families they serve in order to support them in drawing on endogenous resources. Diversity-informed infant mental health practice involves continually revising professional wisdom in light of the lessons learned from infants and families.

5. Honor Diverse Family Structures: Families define who they are comprised of and how they are structured; no particular family constellation or organization is inherently optimal compared to any other. Diversity-informed infant mental health practice recognizes and strives to counter the historical bias toward idealizing (and conversely blaming) biological mothers as primary caregivers while overlooking the critical child-rearing contributions of other parents and caregivers including fathers, second mothers, foster parents, kin and felt family, early care and educational providers, and others.

Although this Tenet may at first glance appear to be simple to embrace, fully implementing it would entail a radical reworking of infant mental health discourse and practice. As was discussed in the section above, most studies of typical early childhood development have been normed on middle class, able-bodied children of European-American descent. In addition, most of these children represent (or are assumed to represent) nuclear families with heterosexual parents. (It is quite rare to come across an infant mental health text acknowledging the prevalence of gay parenthood that is not specifically addressing an issue related to parental sexual orientation.) Whenever heterosexual, white, middle class, able-bodied nuclear families are represented as the norm and biological mothers are assumed to be the only salient caregivers, historical biases are reproduced and further entrenched. These ideas reinforce barriers to a more accurate and inclusive recognition of the reality of family diversity.

A notable exception is James P. McHale's and Elisabeth Fivaz-Depeursinge's (2010) discussion of co-parenting in infancy and early childhood. They state that since the mid-1990s, there has been an upsurge in both basic and applied research studies of co-parenting, though most published reports have involved two-parent Western nuclear families headed by children's mothers and fathers. This has been an unfortunate, unnecessarily limiting constraint, because co-parenting alliances exist in all families where more than just one person assumes responsibility for a child's care and upbringing (p. 354). McHale and Fivaz-Depeursinge go on to state clearly and inclusively that "in heterosexual two-parent family systems, the key co-parenting figures will be the child's mother and father. In gay and lesbian two-parent family systems, it is the two women or the two men raising the child together" (p. 361). In recognition of the unequivocal findings of decades of empirical research demonstrating that there are no adverse child outcomes associated with gay parenthood (American Psychological Association, 2005; Gatrell & Bos, 2010), diversity-informed infant mental health discourse follows the example of McHale and Fivaz-Depeursinge in using inclusive language to redress the historical tendency in the literatures that comprise the field to either omit any reference to gay people and their families (rendering them invisible) or represent them in terms of pathology. Diversity-informed infant mental health agencies review program materials, such as intake forms, to ensure that inclusive terms such

as "parent or guardian" are used rather than the standard heteronormative structure of "mother and father." Logos, flyers, posters, and other imagery are also examined with an eye toward heteronormativity versus inclusivity.

Along similar lines, diversity-informed infant mental health practitioners recognize that single parent families, adolescent parents, divorced parents, parents with disabilities, extended kin networks, and other nondominant parental and family constellations have often been erroneously assumed to provide less optimal child-rearing environments than heterosexual, able-bodied nuclear families. Often adversity factors disproportionately affecting particular parenting groups (e.g., higher rates of poverty associated with adolescent parents) are conflated with those parents' competency, resulting in the idea that it is a parent's age rather than his or her socioeconomic status that poses a "risk" with respect to child well-being. Diversity-informed infant mental health practitioners combat such discrimination and stereotyping by affirming and including a wide range of family structures and learning directly from families which adults are important in the child's caregiving circle.

Embracing Tenet #5 entails a radical reworking of long-held discursive conventions and structures of thought. The idea of "the mother" as primary caregiver runs deep not only within the professional literatures comprising the field of infant mental health, but across artistic and popular cultural media, and throughout society at large. And indeed, in many instances biological mothers do provide disproportionate amounts of infant care and do hold positions of unique and inestimable importance for developing children. But it is readily recognized that while an infant requires such devoted caregiving in order to survive and thrive, this caregiving need not be provided by a biological mother. Adoptive mothers, fathers, grandmothers and grandfathers, aunts and uncles, other "felt family," or psychological parents with no blood relation to a child may successfully assume the role of sole or primary caregiver or may be critical members of a caregiving network.

When professional infant mental health literature continues to refer to primary caregivers as mothers by default, it reinforces this dominant norm as universal and optimal, lending professional authority and sanction to this construct. One will often encounter a footnote on the first page of a professional paper

addressing some aspect of parenting that reads something like this: “While the term ‘mother’ is used in this article to refer to the primary caregiver, the authors recognize that fathers and others sometimes serve in this capacity...” A caveat or disclaimer such as this stops short of truly including fathers and other potential important caregivers. In fact, in an insidious way it excludes them and justifies it by suggesting that their contributions are exceptional, special case instances—literally marginal. In this way infant mental health discourse tends to serve a “gatekeeping” function (Pruett, 1997), regulating and undermining the involvement of fathers and others in child rearing by reproducing, naturalizing, and romanticizing the dominant norm and disregarding the reality of the critical roles played in child rearing by other caregivers even when biological mothers are involved.

Practice/Research Field Principles

6. Understand That Language Can Be Used to Hurt or Heal: Diversity-informed infant mental health practice recognizes the power of language to divide or connect, denigrate or celebrate, hurt or heal. Practitioners strive to use language (including “body language,” imagery, and other modes of nonverbal communication) in ways that most inclusively support infants and toddlers and their families, caregivers, and communities.

Part of the structuring of the human psyche and of the social order happens through language. Consider, for example, the long history of the use of the universal masculine in the English language, wherein a subject was by default referred to in the masculine unless specifically marked as different from/other than the masculine norm (e.g., “the infant at his mother’s breast”). Despite the fact that (through hard work on the part of many people) this convention has changed such that it is no longer acceptable in scholarly discourse to use the universal masculine, many injurious linguistic practices persist, some in the form of conventions and some in the form of individual instances of expression.

For example, it is important to examine the conventions and language around disability. Linton (2006) asserted that professionals must re-look at the most basic assumption of the “nondisabled position and its privilege and power. It is not the neutral, universal position from which disabled people deviate, rather it is a category of people whose power and cultural capital keep them at the

center” (p.171). The social construction of ability and disability interacts with the social construction of self and powerfully influences how people come to see themselves. Rousso (1985), a psychotherapist and an adult with a disability, wrote that an infant or young child experiences a physical disability as an inherent part of the body and self which needs appreciation, acceptance, and affirmation. The moment with the most potential for emotional trauma comes not when the child realizes there is a difference but when the child discovers that the differences are perceived by society as inferior (Rousso). The discovery of this meaning does not happen in a vacuum but is shaped by society’s views and by our views as professionals. Language is a part of that perspective shaping process. Language that empowers the person rather than the condition (a child with autism rather than an autistic child) promotes well-being (Snow, 2009). Language which confuses disability with perpetual suffering, passivity, or superhuman status constricts rather than opens the possibility for full development (Linton). Perspectives on disability which imply a fix-it rather than a whole person view confuse normality with full humanness (Turnbull & Turnbull, 1986). Within this fix-it framework, the parent–infant relationship shifts from nurturance to treatment and the child’s worth is reflected through progress.

As is true in any field, all of the professional and scholarly discourses that comprise infant mental health are prone to reiterating turns of phrase, structures of thought, and systems of meaning that denigrate or exclude individuals or groups in insidious ways. Diversity-informed infant mental health practice therefore attends carefully to words—written and spoken, on posters and flyers and intake forms, in articles and research protocols, in policy and public awareness campaigns in an attempt to be affirmative and inclusive with respect to the experience of all infants, toddlers, families, and communities.

7. Support Families in Their Preferred Language: Families are best supported in facilitating infants’ development and mental health when services are available in their native languages.

The National Standards on Culturally and Linguistically Appropriate Services (Office of Minority Health, n.d.) mandated that health care organizations receiving federal funding make linguistically appropriate services available to clients (Aronson Fontes, 2005). It is recommended that all agencies and practitioners, regardless

of funding sources, also strive to uphold these standards. Although translation and interpretation supports are an important vehicle for combating disparities in access to infant mental health services and resources, they should always be considered to be a triage effort and a temporary measure signaling the need for expanded linguistic competence (and associated cultural attunement) in the workforce. Many core developmental and parenting issues are subtle, complex, and highly emotionally charged. Much is lost in translation when an interpreter is used or when parents are forced to speak in a language other than their native one. When services are unavailable in families’ native languages, the message sent is that the services are not for them, and more broadly that their infants have not been anticipated and are not welcomed by the dominant society or its systems of care.

Linguistically appropriate service delivery is especially important in the field of infant mental health because of the central role played by language acquisition in all realms of development and the salience of the language to the meaning-making potential of caregiving relationships. Parents and caregivers draw on their own preverbal and early language-saturated caregiving experiences in tending their own children. Language develops and acquires meaning in the context of the relationships with the significant others upon whom children depend. These people in turn depended upon others as children, and through the interface with the socio-cultural, political, geographical, and historical conditions that influenced the adults as children a great deal of cultural knowledge is transmitted along with language acquisition.. The language or languages that were acquired in early childhood are deeply entwined with children’s and adults’ internalized representations of themselves and of the other people they learn languages from. These languages become integral aspects of the self experience and of the relationship with those language-specific relationships. Language therefore, is closely linked with identity and is also part of coping and defense mechanisms (Javier, 1989 cited by Madrid n.d.; Pérez-Foster, (2001, 2008). In addition, according to Santiago-Rivera and Altarriba (2002), certain experiences seem to be intimately connected to the first language learned and cannot be “recoded”(p. 34) in another language, no matter how proficient and cognitively integrated in both languages is the bilingual individual. The notion of the “native tongue” and its centrality to the cognitive, affective, and sensorial dimensions of early experiences, underscores the importance

of using therapeutic interventions that are linguistically appropriate when serving immigrant infants, parents, and communities.

8. Allocate Resources to Systems Change:

Diversity and inclusion must be proactively considered in undertaking any piece of infant mental health work. Such consideration requires the allocation of resources such as time and money for this purpose and is best ensured when opportunities for reflection with colleagues and mentors as well as on-going training and consultation opportunities are embedded in agencies, institutions, and systems of care.

Diversity-informed infant mental health practice connotes a stance as much as a focus. For example, although specific diversity issues may appear on the agenda of a staff meeting at a particular agency, diversity-informed agency culture is as much reflected in the question of who creates the agenda, what diversity qualities are embodied in staff members, or how this matches or contrasts with the diversity qualities of families served. Every infant mental health undertaking has cultural implications, although these may be either considered or ignored. Issues such as the allocation of program resources; the setting of agency priorities; and the accessibility, legibility (social as well as linguistic), and perceived salience of services are all matters that carry cultural meaning. In a society in which issues such as race, class, gender, sexual orientation, disability status, immigration status, and others are fraught with conflict and in many instances saturated with historical trauma, the chances are that if diversity issues are not addressed deliberately they will be played out covertly in ways that may replicate injurious patterns in society at large or reproduce historical injustices. For these reasons best practice entails the proactive dedication of time and financial resources for planning and reflection regarding diversity issues.

Because these matters tend to be emotionally fraught for individuals as well as for groups, it is critical that every infant mental health practitioner have predictable access to a colleague or mentor with whom to deeply consider personal meanings of diversity issues. One of the gifts of the field of infant mental health to the wider professional world is an understanding of the importance of the on-going cultivation of a reflective stance as a matter of continued professional development. A paradigm shift has occurred, for example, in many mental health and social service

disciplines away from purely administrative or educative supervision and toward reflective supervision. Because of the deep roots in this practice, infant mental health practitioners have contributed substantially to this evolution. It is clear to infant mental health practitioners that a caregiver's capacity for reflection, and specifically for "holding the baby in mind", is a key factor in determining the quality of the caregiver-child relationship and shaping the child's own developing capacity for thinking, feeling, and relating. The field of infant mental health has also long recognized the power of parallel process—how mutually influencing the parent-child and the practitioner-family relationships often are. A commitment to making space for consistent personal reflection is grounded in respect for these powerful processes. Building on this insight and commitment to personal reflection, diversity-informed infant mental health programs, agencies, and systems dedicate resources to providing on-going opportunities on individual and group levels for genuine engagement with the social justice issues on which infant mental health depends.

9. Make Space and Open Pathways for Diverse Professionals: Infant mental health workforces will be most dynamic and effective when culturally diverse individuals have access to a wide range of roles, disciplines, and modes of practice and influence.

Dominant structures of power and forces of oppression have long conspired to systematically limit the access of people of color and other minority groups including persons with disabilities to white collar and high status professions and to positions of influence in trades, institutions, and systems. The National Research Council and Institute of Medicine (2000) noted that "significant cultural distance between providers and recipients of health and human services can make it difficult to build and sustain the kinds of relationships that often determine the short-term acceptability and ultimate success of an early childhood intervention or family support program" (p. 66). Such cultural distance furthermore serves to reproduce injurious divisions within the social order that construct certain groups of people as ill, ignorant, or lacking while other groups are elevated to the status of healers, educators, and purveyors of resources. In the words of Banerjee Brown (2007), "Privilege and discrimination are made possible because of one another" (p. 19).

In order to counter this historical and contemporary reality, infant mental health agencies, systems of care, and

training programs must proactively recruit and promote people of color and representatives of other minority groups not only into the field, but into positions of leadership. This is not possible unless individuals are prepared to recognize and relinquish the unearned power or status that constitutes privilege (McIntosh, 2002). The recognition that one may have unwittingly long benefited from racism and other forms of oppression is painful and requires significant personal reflective work that must be supported at a systems level by consistently available diversity-informed reflective consultation, supervision, or mentorship. Such consultation, supervision, or mentorship is likewise essential for those "swimming upstream" to assume leadership positions contrary to historical and contemporary trends, as personal issues such as internalized racism, or homophobia, and survival (or "thrival") guilt may, without ongoing support, impede individual success and hence hold back progress in the field and harm infants, toddlers, and families.

Broader Advocacy

10. Advance Policy That Supports All Families: Diversity-informed infant mental health practitioners, regardless of professional affiliation, seek to understand the impact of social policies and programs on diverse infants and toddlers and to advance a just policy agenda for and with families.

Professionals in the field of infant mental health play an integral role in the lives of families. Regardless of professional status, infant mental health practitioners advocate for families within their settings and in formal and informal policy and advocacy efforts. When advocating on behalf of families, diversity-informed infant mental health practitioners are conscious not to impose their own values on clients, but to instead understand the experience and self-definition of the infant, family, or community, and consider how the proposed policy or advocacy will impact family and community life. This disciplined consideration of the experience of the other requires ongoing personal reflection about one's own individual experience, as well as an understanding of the role of racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression, as discussed in relation to Tenet #1. Tenet #10 holds that such personal and professional reflection must also be translated into action at the

policy level on whatever small or large scale is possible in keeping with the resources of the practitioner, program, or system of care.

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Maria Seymour St. John, PhD, MFT, is assistant clinical professor in the Department of Psychiatry at the University of California, San Francisco and director of training of the Infant-Parent Program at San Francisco General Hospital. Endorsed by the California Center for Infant-Family and Early Childhood Mental Health as an Infant-Family and Early Childhood Mental Health Specialist, a Reflective Facilitator II and a Mentor, Dr. St. John has published on subjects related to race, class, gender, and sexuality in infant mental health work in numerous books and journals including *Zero to Three*, *Feminist Studies*, *Studies in Gender and Sexuality*, *Attachment and Sexuality*, and the *World Association of Infant Mental Health Handbook of Infant Mental Health*. Her writing examines infant mental health discourse and practice from the perspectives of psychoanalytic, feminist, queer, and postcolonial theories.

Kandace Thomas, MPP, is a program officer at the Irving Harris Foundation, where she plays a leadership role in the Foundation's efforts integrating early childhood development and child trauma knowledge and principles into systems serving young children, including domestic violence prevention and treatment programs, child welfare, and pediatric training programs. In this capacity, she manages grants and special projects in the field of early childhood mental health and child trauma, domestic violence, reproductive health, and social justice. In her work, Kandace partners with local and national grantees to build the capacity of organizations and systems to incorporate child development best practices into their work. Kandace has been instrumental in creating the Diversity-Informed Infant Mental Health Tenets, a list of ten guiding principles outlining standards of practice in the infant mental health field that point the way to an equitable society through engaged professional practice. Kandace is also a doctoral student at Erikson Institute.

Carmen Rosa Noroña, MSW, MS, Ed., CEIS is from Ecuador where she was trained and practiced as a clinical psychologist and also served as a consultant in two UNICEF-funded projects for abandoned young children. She is the clinical coordinator of the Child Witness to Violence Project /associate director of the Boston Site Early Trauma Treatment Network at Boston Medical Center-Division of Developmental and Behavioral Pediatrics. For 20 years, Carmen Rosa has provided clinical services to infants and toddlers and their families in a variety of settings including early intervention, home, and community-based programs. She co-developed the Birth to Three Clinic at Boston Medical Center and was a Fussy Baby specialist at Baby Steps a NICU follow-up clinic for fragile babies and their parents. She is a senior Child-Parent Psychotherapy Trainer and her practice and research interests are on the impact of trauma on attachment, the intersection of culture, immigration and trauma, tailoring mental health services to new immigrant families, and on cross-cultural supervision and consultation. She is a member of the Culture Consortium of the National Child Traumatic Stress Network and has translated and adapted materials for Spanish-speaking families affected by trauma.

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On page 10, the authors refer to the Michigan Association for IMH's (MI-AIMH) practice standards. However, since this writing, the authors have learned that the MI-AIMH's interdisciplinary endorsement includes culturally sensitive, relationship-focused practice promoting infant mental health. Please see:

Michigan Association for Infant Mental Health. (2002a). *Competency guidelines*. Southgate, MI: Author.

Michigan Association for Infant Mental Health. (2002b). *Endorsement for culturally sensitive, relationship-focused practice promoting infant mental health*. Southgate, MI: Author.

Dr. T Berry Brazelton Awarded Presidential Citizens Medal 2012

Dr. Brazelton has been recognized for 60-years of pioneering contributions to pediatrics and child development.

President Obama awarded Dr. Brazelton the Presidential Citizens Medal, the nation's second-highest civilian honor. President Obama recognized Dr. Brazelton, 95, for his pioneering contributions to the field of pediatrics and child development. His ground breaking Neonatal Behavioral Assessment Scale (NBAS) is now used worldwide to recognize the physical and neurological responses of newborns, as well as emotional well-being and individual differences. His innovative, evidence-based approach to child development consists of practical tools and resources designed to strengthen parent-child relationships, help parents understand their child's strengths and behaviors, and encourage full communities to unite around promoting children's healthy development.

Dr. Brazelton's work reflects a critical focus of President Obama's agenda in the second-term. The President highlighted in his State of the Union Address on Tuesday the importance of promoting children's early learning and guaranteeing high-quality pre-school programs for all children, despite family income level.

The Brazelton Touchpoints Center was founded by Dr. Brazelton at Boston Children's Hospital in 1996 with the goal of promoting strengths-based, family-centered care.

About Dr. T Berry Brazelton

The author of more than 35 books and more than 200 scientific papers, Dr. Brazelton has spent his career focused on topics such as individual differences among newborns, the parent-infant attachment, the importance of early intervention to at-risk infants, and opportunities for strengthening families in early infancy. He also shared expertise as host of the popular TV show, «What Every Baby Knows,» which aired from 1983 to 1995.

A renowned advocate for families with young children, Dr. Brazelton was a pivotal supporter of the enactment of the 1993 Family and Medical Leave Act, which guarantees three months of maternity



Dr. Brazelton and Barack Obama. Photo by Robin Leeds.

leave, as well as Public Law 99457, which extends rights and protections of the Individuals with Disabilities Education Act to young children.

Dr. Brazelton has served as Clinical Professor of Pediatrics Emeritus at Harvard Medical School since 1988.

About Brazelton Touchpoints Center

Founded by Dr. T Berry Brazelton at Boston Children's Hospital in 1996, the Brazelton Touchpoints Center® offers innovative, strength-based interventions and practices to equip and engage families, caregivers, and practitioners to successfully support all domains of children's development essential to successful early learning and lifelong success. The Center offers resources related to professional development, research and evaluation, practice innovation and technical assistance, as well as public advocacy focused on systematic change for children and families. Since its inception, the Brazelton Touchpoints Center® has brought Touchpoints principles and strategies to all 50 states, the District of Columbia, and eight American Indian Tribes. The Center's approach has been embraced by tens of thousands of providers in early care and education, health care, and early intervention, reaching more than one million families across the country. For more information, please visit: <http://www.brazeltontouchpoints.org/>.

Source: Brazelton Touchpoints Center

Book review

By Deborah Weatherston, Michigan Association for Infant Mental Health

"Nurturing Children and Families: Building on the Legacy of T. Berry Brazelton," B. Lester and J. Sparrow, Eds. (2010)

"Nurturing Children and Families: Building on the Legacy of T. Berry Brazelton," edited by Barry M. Lester and Joshua D. Sparrow, invites readers to reflect on and celebrate the remarkable contributions that T. Berry Brazelton has made to the advance of science and the nurturing of infants, children and their families. The book introduces us to significant concepts that have challenged how scientists and practitioners view babies and witness the relational nature of human development over the span of his 50 year career. Concepts that are most important to mention here: individual differences in infancy and the dynamics of newborn behavior; the infant's contributions to his or her own course of development; the power of the parent-child relationship to influence health, growth and change; and the importance of shared observation and meaning making in early work with families. Brazelton's pioneering spirit has transformed practice, inviting pediatricians, nurses, psychologists, social workers, home visitors, early care and education professionals and many others to be open, curious, and thoughtful in their observations, interactions and affective responses to infants and families. Of great importance is Brazelton's therapeutic stance that has guided generations of parents to feel confident and competent as they cared for their babies in the early years.

The book is laid out in three separate parts. Part I discusses Brazelton's accomplishments in terms of behavioral and developmental research. Part II explores innovations in clinical intervention, including a section about infant mental health and the treatment of trauma. Part III discusses the implications of Brazelton's work for professional development, systems of care, and policy. Chapter by chapter, the book is a masterful collection of writings from among the most respected scientists and clinical leaders in the infant and family field. Each contributor invites readers to think more deeply about early development, relational contexts, and touchpoints for optimal growth and change. What follows is a brief introduction to each part.

Part I introduces the reader to the transformations in research and practice that are attributed to T. Berry Brazelton. Barry Lester describes paradigms that Brazelton challenged and praised the "new lens through which we see and study children based on his scientific contributions." p. 3. Joshua Sparrow follows with an illuminating chapter in which he examines Brazelton's transformative ideas about infants and observation, individual differences, culture and development, and collaborative consultation. Part I continues with a focus on advances in fetal and newborn behavior, self-regulatory and relational processes, regression and reorganization in infancy, and neuroscience perspectives on developmental models. The range of topics is stunning, reflecting the depth and breadth of Brazelton's thinking by colleagues and authors, Kathryn Barnard, Tiffany Field, Daniel Stern, Ed Tronick, Stanley Greenspan, Allan Shore, and Jerome Kagan, to name a few.

Part II includes discussions of innovative clinical interventions for infants and parents that are relationship based. Included are Touchpoints®, Nurse Family Partnerships (NFP), the care of preterm infants (NIDCAP), and the use of the Neonatal Behavioral Assessment Scale (NBAS) to encourage parent-infant interaction. Charles and Paula Zeanah, Joy and Howard Osofsky, Dante Cicchetti and Sheree Toth offer perspectives on infant mental health. They address core concepts that reflect Brazelton's considerable contributions to our understanding of the field. It is clearly a multidisciplinary field that focuses on strengths; it is relational; it is observational, collaborative and insightful.

The discussion about "ghosts in the nursery" and angels in this section, written by Alicia Lieberman and William Harris, has particular meaning for the infant mental health community. The authors align the thinking and work of two important pioneers, T. Berry Brazelton and Selma Fraiberg:

Brazelton observed, Fraiberg observed – and both intervened, each as a different segment of the health – pathology spectrum. Brazelton promoted awe, pleasure, and competence in parents who were often seeing the wondrous capacities of their babies for the first time. Through their babies' responses to them, parents developed a

reinforcing sense of self-efficacy. ..Fraiberg focused on parents whose capacity to connect to the unique individuality of their baby was thwarted by their negative attributions, rooted in their own childhood experiences of having felt unprotected and unloved. Brazelton was working through a lens of optimism, using the baby's competence to help parents discover their own; Fraiberg was focusing on the mother's psychopathology, using the baby's potential to help the mother escape from entrapment in her own past. Together, they created a chiaroscuro that honors the complexity of what Daniel Stern calls 'the first relationship.'" P. 243-44.

Their work led to relationship as a focus for the promotion and practice of infant mental health, a significant shift in the delivery of developmental and clinical services for infants, toddlers and families. We are challenged by the authors in Part III to take the principles of relationship work, so central to Brazelton and Fraiberg, and apply them across disciplines, systems, and organizations to effect continued growth and change through collaboration in this rich and rapidly expanding field.

Part III contributors discuss the implications of Brazelton's work across disciplines and systems of care. Libby Zimmerman offers observations about developing the infant mental health workforce. Jayne Singer and John Hornstein discuss Touchpoints® for early care and education providers. Constance Keefer examines early innovations in behavioral/developmental pediatric training. Change is the focus for the concluding chapters. Myra Fox addresses change in service delivery in hospital environments. Ann Stadtler, Julie Novak, and Joshua Sparrow present improvements in healthcare service delivery with relationship-based nursing practices. Daniel Pederson and Jack Shonkoff translate the science of early childhood development into policy and practice.

Sarah Lawrence-Lightfoot's concluding reflections about Brazelton are heartfelt:

As we honor and learn from the luminous life and work of Berry Brazelton, we take his lessons and make them our own, hearing

the echoes of his teachings and giving them our singular voice and commitment. Now is the time. Now is always. p. 362

When I turned the to last page of this extraordinary collection, I drew a deep, reverent breath. What a remarkable man T. Berry Brazelton is. He has contributed so much to shared understanding of the importance of infancy and the power of nurturing relationships to growth, health, and change. This classic collection will enrich every infant mental health professional's understanding of the legacy of T. Berry Brazelton and his influence on the infant and family field.

NAIMH introduction

By Catarina Furmark, President, Nordic Association for Infant Mental Health

Introduction

The Nordic countries - Denmark, Norway and Sweden - each have a relatively small population, totaling around 20 million. Reflecting the three individual countries differences in political structures, in social systems and in policies, the Nordic Association of Infant Mental Health, NAIMH, or NFSU in Scandinavian, is a diverse affiliate. The total membership of NAIMH fluctuates from around 200 to 350 members. Each country is responsible for hosting activities for their members and takes turns in organizing annual conferences.

The Structure of NAIMH

Members elect board members for two years, with the option to be re-elected for two more years. The term of office is limited in time to ensure that all countries are represented in an equal manner. The President or Chairperson is elected, whereas the positions of Vice President, Secretary and Treasurer (the latter for each country) are decided by the elected board. The board consists of two representatives from each country, enabling a rich exchange of ideas and inspiration from the different parts of Scandinavia. The position as Chair alternates between the countries.

Communication with the Members

The President is responsible for the publication of bi-monthly newsletters. Recently the affiliations' website underwent an overhaul and is now the most effective and up-to-date manner in which to communicate with the members. <http://www.nfsu.org> Occasionally a guest-blogger is invited to add an interesting glimpse into his or her professional world. But mostly the site is used for information on seminars, training, conferences and happenings worldwide as well as book reviews, updates on research articles. We even have a twitter account linked to the website with frequent «tweets» by the current President - @BarnPsykologen - as well as the current Secretary - @HanneCB.

Affiliates Corner

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Background

The idea of a Nordic network was first presented at the Lugano WAIMH-conference in 1989. When a handful of Infant Mental Health professionals got together in Sweden in 1991, they launched the Nordic Association for Infant Mental Health or NFSU in Scandinavian. One of the early aims was to establish a connection with the international body of infant research and professional training programmes. That year, the group presented the idea of a Nordic network at the WAIMH Congress in Chicago and received a very warm welcome. NFSU/NAIMH was one of the very first affiliates to be a part of WAIMH, and the connection with WAIMH remains a strong one. We encourage our members to take up dual memberships whenever possible. NFSU/NAIMH also continues to seek out ways to collaborate with other national organizations. For example, in Sweden, the "Psychologists in MCH-care", and in Norway, Regional Centers for Child and Adolescent Mental Health (the R-BUP/ the RKBU), along with others. The aim to be a part of the international infant mental health world is imperative to us. We seek collaboration and exchange in a multitude of ways, whether it is on a more formal level, in the area of training, in the field of research or more personal contacts and meetings with fellow professionals and friends within the network and around the world.

Annual National Infant Mental Health (IMH) Conferences

NFSU has organized and held two-day IMH conferences each year since the Nordic network was formed. The three member countries take turns in planning and hosting the conferences, making it easier for all members from the various areas of Scandinavia to attend.

Our most recent NFSU conference was held in Bergen, Norway, with approx. 100 in attendance. Since our 20th jubilee conference in Copenhagen where Antoine Guedeney gave an honorary talk, the opening plenaries are held in English, followed by presentations in the Scandinavian languages the second day. The Scandinavian languages - Norwegian, Danish and Swedish- although distinct from one another, can be fairly easily understood by each of the different

nationalities! This way the presenters may choose which language they are most comfortable with presenting in, while opening up the conferences for non-Scandinavian speakers. To our delight our colleagues in Finland and Iceland, attend in greater numbers. It has also enabled the board to increase the collaboration with WAIMH, and to work together with sponsors to offer interesting and important keynotes from distinguished colleagues in the field. At last year conference in Stockholm, Miri Keren honored us with an inspiring and heartfelt talk on her work. This year in Bergen, Zack Boukydis graced us with his presence, giving a presentation on his seminal work with neonates illustrated in Collaboration and Collaboration with Infants and their parents.

As Lynn Priddis highlighted when introducing us to the Australian affiliate model, the Nordic conferences are governed by the context in which they occur with each committee who organizes the event adding local color to the meetings. In Bergen we travelled high up in the mountains by funicular to enjoy a lovely Norwegian meal high above the fjords. In Stockholm we looked out on the sea covered in glistening snow and ice while listening to our colleagues. And in Copenhagen we celebrated twenty years of IMH network in Scandinavia with a theatre piece and an introduction to our honorary members.

Network Activities

When looking at the NFSU/NAIMH website, www.nfsu.org, one can tell there is a lot of activity going on (one can only read it if one is fluent in Scandinavian.. we are working on an English version...). The board hosts events throughout the year for the members, but also encourages members to create their own events, seminars etc. The board has also initiated events inviting non-members to join as a way to enroll more members. Here we may collaborate with other members of WAIMH to offer lectures, and we also occasionally co-host events with the national Child and Adolescent Psychiatric Divisions and regional universities. We call these gatherings "NFSU-café's" and they can center around almost any relevant topic members initiate. Most recently Helen Minnis came to Stockholm to inform members on the current state of research regarding Reactive Attachment Disorder, member Marianne Velandia presented her important thesis on skin-to-skin after Cesaerean deliveries etc. Another example on how the network has been useful to its members is the arranging of a pre-conference meeting of the colleagues who

From the Affiliates

By Maree Foley, WAIMH Affiliate Council Representative, New Zealand, Jane Barlow, Chair of the Local Organizing Committee, WAIMH World Congress 2014, United Kingdom and Martin St-André, WAIMH Affiliate Council Chairperson, Canada

In preparation for the 2014 WAIMH Congress in Edinburgh, the UK Affiliate, with WAIMH and the Affiliates Council, have been working together to run a pre-congress event that specifically addresses reflective supervision, a continuing education need that was identified from the affiliates surveys as an issue of interest for many of us. A reflective supervision pre-congress event is therefore being organized, in order to offer an experience of a live supervision format. Two colleagues have offered to take the supervisor role: Louise Emmanuel representing the UK affiliate, and Pamela Segel, representing the broader affiliate community. Both Louise and Pamela are very experienced and highly regarded supervisors.

We are now seeking to identify two colleagues- one from the UK Affiliate, and one from any other Affiliate - who would be willing to take part in the live supervision as supervisees. The recruiting process uses our emerging communication infrastructure for Affiliates: the message was distributed on the Affiliates presidents' mailing list and was also posted on the Affiliates Facebook page, to which all Presidents and Affiliates Board members are once again invited to join in by contacting Catarina Furmark (cfurmark@gmail.com) or Lynn Priddis (lpriddis@curtin.edu.au). For this event to be a success, we are looking for two practitioners who have considerable

work within the neonatal wards.

Collaboration

As previously mentioned, NAIMH values the close collaboration with WAIMH. Most recently this resulted in the arrangement of a training seminar, in the use of the Alarm Distress Baby Scale (ADBB). Antoine Guedeney, along with members from Norway, gave the training that resulted in a number of newly certified coders primarily in Norway, but also in Sweden. We actively promote the use of the internet to enable communication, one such being the

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experience of reflective supervision. The supervisee would be required to bring a detailed case study, which could be presented in accordance with the usual ethics of supervision with regard to case presentation to ensure the anonymity of the patient/client. Being a supervisee would entail presenting a detailed processed record of a clinical encounter, depending on their work context, with minimal but essential background history. The supervisee would also need to be willing to engage in an extended discussion (for around an hour) with one of the two nominated supervisors, and with a potential audience of around 50 people (although this may be as many as 100).

If you would be interested in being a supervisee, we ask that you email the WAIMH office (office@waimh.org) with the following information:

- Name
- Affiliate
- Professional credentials and ethical body
- Experience to date of reflective supervision
- A brief statement about what you think as a supervisee you would bring to this process.

The selection process will be overseen by WAIMH, the Affiliates Council, and the local organizing committee for the WAIMH congress, and all applicants will be notified about the outcome of their application later in the year. The closing date for applications is: July 15, 2013.

In the meantime, our best wishes for a dynamic spring period for your Affiliate.

closed Facebook group for affiliate board members just established following the affiliate meeting in Cape Town.

Finally...

I would like to invite you all to our next annual conference, which will be hosted by the Danish branch of NAIMH, with our very promising and enthusiastic organizing committee based in Copenhagen. The preliminary dates are March 7-8, 2014. Mark it in your Calendar! Wishing you a very warm welcome to Scandinavia.

Info for WAIMH members

WAIMH Affiliate organizations in 2013



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Infant Mental Health Journal

As a member of the WAIMH community, we know that you share in our mission to promote and support nurturing relationships for all infants. Given our common goals, we believe that our journal, *Infant Mental Health Journal* (IMHJ), is an important resource for you.

Available online and in print, IMHJ publishes peer reviewed research articles, program descriptions/evaluations, clinical studies, and book reviews that focus on infant social-emotional development, caregiver-infant interactions, contextual and cultural influences on infant and family development, and all conditions

that place infants and/or their families at risk for less than optimal development. The Journal is dedicated to an interdisciplinary approach to the optimal development of infants and their families, and therefore, welcomes submissions from all disciplinary perspectives, for example, psychology, pediatrics, social work, early childhood, special education, early intervention, and psychiatry.

A subscription to IMHJ is available a special rate for WAIMH members. Click the WAIMH website for more information.

From the Kauppi Campus -News from WAIMH Central Office

By Päivi Kaukonen, Kaija Puura and Minna Sorsa, Finland

Dear WAIMH members,

In the last Perspectives we asked for your contribution for the election of new WAIMH Board members. We want to thank all the active members, who cast their vote and the candidates for running for the WAIMH Board and for their willingness to work on behalf of WAIMH.

We are happy to announce that the two new WAIMH Board members for the years 2013-2017 are Astrid Berg and Campbell Paul. Congratulations!

Altogether 996 WAIMH members (2012 or 2013) were eligible to vote in the election taking place 7th May- 9th June 2013 (GMT). One member could vote for two candidates. A total of 341 members cast their vote – a higher number than ever before. The voter turnout was at 34,24 %. All the 46 new members who paid their membership fee during the month of election were given the possibility to cast their vote.

All candidates were popular and there was quite an even distribution of vote.

Astrid Berg	154
Vibeke Moe	98
Campbell Paul	141
Joshua Sparrow	111
Hisako Watanabe	137

It is now roughly a year to the next WAIMH World Congress will take place 14-18 June 2014 in Edinburgh. The theme for the Congress is "Babies: Their Contributions, Our Responsibilities". The Call for Papers is available at the official congress site and also on the WAIMH website; the deadline for abstract submission is 15th September, 2013. We warmly welcome clinicians and researchers from all over the world to submit their work in form of posters, poster workshops, symposia, workshops, videos and clinical teach-ins. Information and details on how to submit is given in the Call for Papers. Presenting in WAIMH Congress is a wonderful way of sharing your own knowledge and skills and to learn from others' experience through fruitful discussion in and between congress sessions.

In the Edinburgh congress high class plenaries will be given by James Swain, Pasco Fearon, Karlen Lyons-Ruth, Christine Anzieu-Premmereur and Jane Barlow. As has been our tradition, the Congress programme includes also two plenary interfaces with Karl-Heinz Brisch and Franziska Schlensog-Schuster

as presenters. In addition to Congress programme there will be several master classes given by the leading professionals and researchers on the field of infant mental health. And finally, as a part of the preconference programme we will have a novelty: live supervision sessions organised in co-operation with the Affiliates. In addition to attending the Congress, Edinburgh is a beautiful city with a rich history and well worth spending a few days relaxing and sightseeing before or after the Congress. You can also go exploring Scotland by bike or on horse back, or go fishing.

Last but not least, please renew your WAIMH membership online at the WAIMH website 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 in 2013 are: USA 50 USD, Canada 52.50 USD and International orders 62.50 USD. All journal subscriptions are now also including access to the online IMHJ at the Wiley website. Please, contact the WAIMH Central Office, if you need guidelines or support for the membership renewal (office@waimh.org).

We hope you all would be active in promoting WAIMH and our next World Congress. From our website you can print a WAIMH Flyer and the Call for Papers to your colleagues and ask them to join our multidisciplinary and global association for the benefit of infants all over the world.