

# The World in WAIMH

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

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

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

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

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

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

Our shared hope is that this will offer space for challenge and interdisciplinary discussion. We are asking the WAIMH community for commentary, field reports, case studies, research articles, book

reviews, new submissions and (when proper permission can be obtained) adaptations of previously published articles that may be of interest.

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

## INFANT MENTAL HEALTH IN THE GLOBAL VILLAGE.

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

By Niels P. Rygaard

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

#### Introduction

This essay aims to identify some hotspots of future infant research. It was inspired by the 2014 WAIMH Edinburgh conference, and the author's observations from developing international online educations for orphanage and foster care systems. Focusing on risk factors, the text projects current global and urban trends, pointing to possible future environments for infants, in a world where the organization of daily care is undergoing rapid change. The urban infant environment is reflected upon from several perspectives: how may the altering patterns of reproduction, migration and social mobility affect the organization of the family, daily infant care, government child policies, and the abandonment of children? To highlight

the impacts of urbanization on family life, Danish examples representative of global statistics are used. The discussion pertains to the areas of theoretical concepts, possible new designs of studies, and the use of technology to disseminate results and professional dialogue with global audiences. (Topics for debate are in italics).

#### Urbanization, Migration, and Infant Environments

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

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

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

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

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

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

In the circumstance of a reversed age pyramid where the influence and needs of the elderly are a dominant

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

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

## Uneven Tempo of Change - Migration and the Cultural Chessboard City

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

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

and integration.

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

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

## From Preserving Traditional to Constructing Innovative Urban Parenthood

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

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

## The Organization of Urban Infant Care: The Requisite Membership Family

The rural extended-family-clan base, where

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

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

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

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

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

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

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

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

One example in this direction: a major recent survey of international research since the 1930s concludes that in nurseries and kindergartens, three factors influence long term child development, including higher levels of education as adults: fewer children per caregiver, smaller groups of children, and ongoing education of staff. Positive effects are most prominent in

children from disadvantaged risk families. The most important factor is the quality of the interaction between children and adults (Christoffersen, Hoejen-Soerensen, & Laugesen, 2014), concordant with orphanage intervention research.

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

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

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

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

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

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

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

## Major Challenges in Improving the Lives of Children without Parents

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

In the global perspective, the trend of preferring foster care in favor of institutions may be questioned (McCall, 2014): quality foster care requires strong government monitoring systems, usually non-existent

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

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

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

## Discussion

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

## Revisions of theory and research to comply with urban reality

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

## Technology spurring innovative research designs, focusing on vertical validity

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

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

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

and internal physical processes in infants?

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

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

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